

<i>SERFF Tracking Number:</i>	<i>ZURC-126394542</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>44163</i>
<i>Company Tracking Number:</i>	<i>CW AH 29266</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Group Accident Policy</i>		
<i>Project Name/Number:</i>	<i>/CW AH 29266</i>		

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Group Accident Policy	SERFF Tr Num: ZURC-126394542	State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment	SERFF Status: Closed-Approved- Closed	State Tr Num: 44163
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment	Co Tr Num: CW AH 29266	State Status: Approved-Closed
Filing Type: Form	Authors: Patricia Chudik, Karen Falbo	Reviewer(s): Rosalind Minor
	Date Submitted: 11/23/2009	Disposition Date: 12/01/2009
		Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number: CW AH 29266	Date Approved in Domicile: 10/14/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association, Other
Filing Status Changed: 12/01/2009	Explanation for Other Group Market Type: Financial Institutions, Creditors, Credit Unions, Trustees and Vendors, etc.
	State Status Changed: 12/01/2009
Deemer Date:	Created By: Karen Falbo
Submitted By: Karen Falbo	Corresponding Filing Tracking Number:
Filing Description:	
This is a new Group Accident Insurance product, which will be marketed to all statutorily eligible groups in your state consisting of two (2) or more individuals. Eligible groups shall include, but is not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.	
This Group Accident Insurance product may be marketed through brokers, consultants, third party administrators and	

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sales employees.

The plan provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Please see the explanatory for a complete description of this filing.

Company and Contact

Filing Contact Information

Karen Falbo, Product Analyst karen.falbo@zurichna.com
 1400 American Lane 847-605-7545 [Phone]
 Schaumburg, IL 60196 847-605-7768 [FAX]

Filing Company Information

Zurich American Insurance Company CoCode: 16535 State of Domicile: New York
 1400 American Lane Group Code: 212 Company Type:
 Schaumburg, IL 60102 Group Name: State ID Number:
 (847) 605-6000 ext. [Phone] FEIN Number: 36-4233459

Filing Fees

Fee Required? Yes
 Fee Amount: \$650.00
 Retaliatory? No
 Fee Explanation: \$50.00 for each policy & all forms associated with the policy filed with the policy.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$50.00	11/23/2009	32251682

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2009	12/01/2009

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Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-126394542 State: Arkansas

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Company Tracking Number: CW AH 29266

TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment

Product Name: Group Accident Policy

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanatory	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Form	Group Accident Insurance Policy	Approved-Closed	Yes
Form	Application - Group Accident Insurance	Approved-Closed	Yes
Form	Group Accident Insurance Certificate	Approved-Closed	Yes
Form	Blank Endorsement	Approved-Closed	Yes
Form	[Higher] Education Benefit	Approved-Closed	Yes
Form	Common Carrier Benefit	Approved-Closed	Yes
Form	Common Disaster Benefit	Approved-Closed	Yes
Form	Carjacking Benefit	Approved-Closed	Yes
Form	Felonious Assault Benefit	Approved-Closed	Yes
Form	Rehabilitation Benefit	Approved-Closed	Yes
Form	Seat Belt [/ Air Bag] Benefit	Approved-Closed	Yes
Form	Identity Theft Resolution Services Benefit	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: U-GMC-100-A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/01/2009	U-GMC-100-A AR (08/09)	Policy/Cont	Group Accident ract/Fratern Insurance Policy al Certificate	Initial		54.000	U-GMC-100-A AR Group Accident Insurance Policy 11-19-09.pdf
Approved-Closed 12/01/2009	U-GMC-101-A AR (08/09)	Application/Enrollment Form	Application - Group Accident Insurance	Initial		61.000	U-GMC-101-A AR Application 11-19-09.pdf
Approved-Closed 12/01/2009	U-GMC-102-A AR (08/09)	Certificate	Group Accident Insurance Certificate	Initial		58.000	U-GMC-102-A AR Group Accident Insurance Certificate 11-19-09.pdf
Approved-Closed 12/01/2009	U-GMC-104-A CW (08/09)	Policy/Cont	Blank Endorsement ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		43.000	U-GMC-104-A CW Blank Endorsement.pdf
Approved-Closed 12/01/2009	U-GMC-110-A CW (08/09)	Policy/Cont	[Higher] Education ract/Fratern Benefit al Certificate: Amendmen	Initial		47.000	U-GMC-110-A CW [Higher] Education Benefit.pdf

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Approved- U-GMC- Closed 111-A CW 12/01/2009 (08/09)	Policy/Cont Common Carrier ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	44.000	U-GMC-111- A CW Common Carrier Benefit.pdf
Approved- U-GMC- Closed 112-A CW 12/01/2009 (08/09)	Policy/Cont Common Disaster ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	48.000	U-GMC-112- A CW Common Disaster Benefit.pdf
Approved- U-GMC- Closed 113-A CW 12/01/2009 (08/09)	Policy/Cont Carjacking Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	41.000	U-GMC-113- A CW Carjacking Benefit.pdf
Approved- U-GMC- Closed 114-A CW 12/01/2009 (08/09)	Policy/Cont Felonious Assault ract/Fratern Benefit al Certificate: Amendmen t, Insert	Initial	45.000	U-GMC-114- A CW Felonious Assault Benefit.pdf

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<i>Product Name:</i>	<i>Group Accident Policy</i>		
<i>Project Name/Number:</i>	<i>/CW AH 29266</i>		
	Page,		
	Endorseme		
	nt or Rider		
Approved- U-GMC- Closed 115-A CW 12/01/2009 (08/09)	Policy/Cont Rehabilitation Benefit Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	43.000	U-GMC-115- A CW Rehabilitation Benefit.pdf
Approved- U-GMC- Closed 116-A CW 12/01/2009 (08/09)	Policy/Cont Seat Belt [/ Air Bag] Initial ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	38.000	U-GMC-116- A CW Seat Belt [Air Bag] Benefit.pdf
Approved- U-GMC- Closed 118-A CW 12/01/2009 (08/09)	Policy/Cont Identity Theft Initial ract/Fratern Resolution Services al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	37.000	U-GMC-118- A CW Identity Theft Resolution Services Benefit.pdf
Approved- U-GMC- Closed 103-A AR 12/01/2009 (08/09)	Application/ Enrollment Form Initial Enrollment Form	55.000	U-GMC-103- A AR Enrollment Form 11-19- 09.pdf

Group Accident Insurance Policy



ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane
Schaumburg, Illinois 60196

In return for the payment of premium expressed in the Schedule, **We** agree to pay the benefits of this **Policy** to the persons insured hereunder, subject to the terms and conditions which follow. **We** have issued this **Policy** to the **Policyholder**. This **Policy** is executed as of the Policy Inception Date shown in the Schedule which is its date of issue, and from which anniversary dates are measured.

RENEWAL. This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified in the Termination of Insurance provisions shown in Section VII.A.

This **Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

**THIS GROUP ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE [ONLY]
[THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS]**

We and the **Policyholder** have agreed to all the terms of this **Policy**.

This is a legal contract between the **Policyholder** and **Us**.

IN WITNESS WHEREOF, this **Company** has executed and attested these presents and, where required by law, has caused this **Policy** to be countersigned by its duly Authorized Representative(s).

A handwritten signature in cursive script that reads 'Nancy D. Mueller'.

President

A handwritten signature in cursive script that appears to read 'Dan J. K...'.

Corporate Secretary

PLEASE READ THIS POLICY CAREFULLY

NON-PARTICIPATING

TABLE OF CONTENTS

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Section VIII	HOW TO FILE A CLAIM
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SECTION I - SCHEDULE

- I. **POLICYHOLDER:** [John Doe Corporation]
[123 Main Street]
[Anywhere, XX 10011]
[COVERED SUBSIDIARIES OR AFFILIATED COMPANIES: [ABC Company]]
- II. **POLICY NUMBER:** [ABC-1234567]
- III. **POLICY INCEPTION DATE:** [January 1, 2010]
- IV. **POLICY PERIOD:** [Effective Date] to [Expiration Date] [Continuous]
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)
- V. **CONTRACT SITUS:** []
- VI. **ELIGIBILITY AND CLASSIFICATION OF INSUREDS:**

The following individuals are eligible to become **Insureds** upon [completion of the **Service Waiting Period** as indicated below, and] the submission of completed enrollment material, if required:

Class I: [Active Employees working a minimum of [15 hours] per week.] [Active Members]

[Class II: [Retirees] [Past Members]]

[Class III: [Dependents]]

If a **Covered Person** suffers a **Covered Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

[SERVICE WAITING PERIOD:

[[30 days] of **Active** continuous service.]]

VII. **PRINCIPAL SUM:**

Class I: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].

[Class II: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].]]

[The **Principal Sum** for covered **Dependents** will be a percentage of the **Insured's Principal Sum**, on the date of **Accident**, determined by multiplying **Your Principal Sum** by the percentage below.

<u>Plan Selected</u>	<u>% Spouse[/Domestic Partner]</u>	<u>% Child(ren)</u>
Spouse[/Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and Dependent Child(ren);	[40%]	[10%]

VIII. [[AGGREGATE] LIMIT OF LIABILITY [for air travel] [\$5,000,000] per **Covered Accident**

[If the total of all benefits payable for all **Covered Persons** per **Accident**, in the absence of this provision exceeds the above amount, each benefit amount will be proportionately reduced so that the total will equal the above amount.]

[If both **Non-Contributory** and **Contributory** coverage are included, the above list of benefits will be labeled **Non-Contributory** and then the benefits applicable to the **Contributory** coverage will be listed below.]

Benefits payable under any attached Riders are subject to the [Aggregate] **Limit of Liability.**]]

IX. COVERAGES:

COVERAGE	CLASS COVERED	COVERAGE AMOUNT
[Accidental Death [and Dismemberment] Coverage]]	[All]	[Accidental Death [100% of Principal Sum]] [Loss of: 1. Both Hands or Both Feet [100% of Principal Sum] 2. One Hand and One Foot [100% of Principal Sum] 3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum] 4. Sight of Both Eyes [100% of Principal Sum] 5. Speech and Hearing [100% of Principal Sum] 6. Speech or Hearing [50% of Principal Sum] 7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum] 8. Thumb and Index Finger of the same Hand [25% of Principal Sum] 9. Hearing in One Ear [25% of Principal Sum]]
[Exposure and Disappearance Coverage]	[All]	[100% of Principal Sum]
[]	[All]	[]

[X. BENEFIT[S] RIDER[S]:

BENEFIT	CLASS COVERED	BENEFIT AMOUNT	FORM NUMBER
[[Higher] Education Benefit]]	[All]	[[10%] of the [Covered Person's] [Insured's] Principal Sum] [Up to [\$10,000] per [Covered] Dependent Child]	[U-GMC-]
[Common Carrier Benefit]	[All]	[\$50,000] [[50,000] or Up to a maximum of [50%] of the [Covered Person's] [Insured's] Principal Sum]	[U-GMC-]
[Common Disaster Benefit]	[All]	[\$500,000]	[U-GMC-]
[Carjacking Benefit]	[All]	[[10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]	[U-GMC-]
[Felonious Assault Benefit]	[All]	[15%] of the Insured's Principal Sum	[U-GMC-]
[Identity Theft Resolution Services]	[All]	[Identity Theft Resolution Services]	[U-GMC-]
[Rehabilitation Benefit]	[All]	[[10%] of the [Covered Person's] [Insured's] Principal Sum or to a maximum of [\$10,000] [\$10,000]	[U-GMC-]
[Seat Belt/[Air Bag] Benefit]]	[All]	[Seat Belt - [10%] of the	[U-GMC-]

BENEFIT	CLASS COVERED	BENEFIT AMOUNT Principal Sum to a maximum of [\$10,000] [\$10,000] [Air Bag - [10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]	FORM NUMBER
[]	[All]	[]	[U-GMC-]]

XI. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:

[Claims Department
Zurich American Insurance Company,
[P.O. Box 968041, Schaumburg, IL. 60196]]
[1-866-841-4771]

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

[ELIGIBILITY OF INSURED'S DEPENDENTS

[An] **Insured[s]** may elect to cover their eligible **Dependents**. An eligible **Dependent** includes the **Insured's Spouse/Domestic Partner** and the **Insured's Dependent Child(ren)**, [and] [his or her **Spouse's Dependent Child(ren)**] [, and his or her **Domestic Partner's Dependent Child(ren)**]. A **Spouse/Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under this **Policy**. If the **Insured** and his or her **Spouse/Domestic Partner**, or former **Spouse/Domestic Partner** are both **Insured's** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.]

INSURED'S EFFECTIVE DATE

An **Insured's** coverage under this **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the date for which the first premium for the **Insured's** coverage is paid;
3. the date the person becomes a member of an eligible class of persons as described in the Eligibility and Classification of Insureds section of this **Policy**; or
4. [[A. For individuals eligible on [Date]: provided the completed enrollment material is received by **Us** on or prior thereto.]
[B. For individuals eligible on or after [Policy Inception]: [[on the first day of the month following] the date the completed enrollment material is received by **Us**.]] [upon] [on the first day of the month following] completion of the required **Service Waiting Period** indicated above, provided the completed enrollment material is received by **Us** prior thereto.]]

A change in an **Insured's** coverage under this **Policy** due to a change in his or her eligible class becomes effective on the later of:

1. when the change in his or her eligible class occurs; or
2. if the change requires a change in premium, the date the first changed premium is paid.

However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

[ELIGIBLE DEPENDENTS EFFECTIVE DATE

An eligible **Dependent's** coverage under this **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the Insured's Effective Date;
3. the date for which the first premium for the **Dependent's** coverage is paid;
4. the date the person qualifies as a **Dependent**; or
5. [the date on which written enrollment for the **Dependent** is received by **Us**.]

[A child of an **Insured** born while this **Policy** is in force is covered from the moment of birth for a period of 60 days. An adopted newborn child of an **Insured** is covered from the moment of birth for a period of 60 days. After this time, the child will remain covered only if the **Insured** has provided written notice of birth or the filing of a petition for adoption to the **Policyholder** and pays the required premium due, if any.]

[A newly adopted child of an **Insured** is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 60 days. After this time, the child will remain covered only if the **Insured** has provided written notice to the **Policyholder** of the adoption or the filing of a petition for adoption, and pays the required premium due, if any.]

SECTION III – DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

[**Active** means [a member as defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.].]

[**Active** and **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.]

[**Active Employee** means any natural persons in the regular service of the **Policyholder** and in the ordinary course of the **Policyholder's** business.]

[**Active Member** means a member in good standing according to the rules of the **Policyholder**.]

[[**Aggregate**] **Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the [**Aggregate**] **Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [1] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the [**Aggregate**] **Limit of Liability** is not enough to pay full benefits to each [**Covered Person**] [**Insured**], **We** will pay each one a reduced benefit based upon the proportion that the [**Aggregate**] **Limit of Liability** bears to the total benefits which would otherwise be paid.]

Certificate(s) means the Certificate of Insurance issued to each **Insured** summarizing the coverage and benefits of this group accident insurance coverage. **We** will provide the **Policyholder** with a **Certificate**, in either paper or electronic format, for their **Insureds**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**.

[**Contributory** means that the premium payments require that the **Insured** pay all or a portion of the premium.]

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Injury means bodily injury directly caused by **Accidental** means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under this **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.

Covered Person means any person who has insurance under the terms of this **Policy**. It includes the **Insured** [,and his or her **Spouse**[/**Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** is selected.]

Dependent means an **Insured's Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this section. [The **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.]

Dependent Child(ren) means those unmarried **Child(ren)** of the **Insured**, [and] [those unmarried **Child(ren)** of his or her **Spouse**[/**Domestic Partner**]] [, and those unmarried **Child(ren)** [as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**] who rely on the **Insured** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [The **Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.]

[**Domestic Partner** means [a person who qualifies as a **Domestic Partner** under the **Policyholder's** written procedures as on file and approved by **Us**.] [a person who qualifies as a **Domestic Partner** under the law of the state of residence.] [as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**.]]

To qualify as a **Domestic Partner**, the following requirements must be met:

1. [the **Insured** and the **Domestic Partner** must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]
2. [the **Insured** and the **Domestic Partner** must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]

3. [the **Insured** and the **Domestic Partner** must both be at least 18 years of age;]
4. [neither the **Insured** nor the **Domestic Partner** are legally married;]
5. [the **Insured** and the **Domestic Partner** are not **Related** by blood or adoption;]
6. [the **Insured** and the **Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely;] [and]
7. [the **Insured** and the **Domestic Partner** must be of the same sex, and if applicable law permitted, would be married.]

The existence of the relationship between the **Domestic Partner** and the **Insured** must be evidenced by:

1. [the **Domestic Partner** being named as the primary beneficiary in the event of the **Insured's** death under the **Insured's** retirement plan or 401(k) plan, if the **Insured** maintains such a plan;]
2. [at least one of the following:
 - a. designation of the **Domestic Partner** as a primary beneficiary under the **Insured's** will; or
 - b. designation of the **Domestic Partner** as a primary beneficiary for the **Insured's** life insurance;]
3. [at least one of the following:
 - a. joint ownership of real estate (whether by mortgage, lease or deed);
 - b. joint ownership of a motor vehicle; or
 - c. joint ownership of a bank account; and]
4. [a completed, active certification of **Domestic Partner** status form on file with the **Policyholder**.]

To be active, the **Insured** will not have completed a Termination of **Domestic Partner** status form with respect to the **Domestic Partner** who is to be covered under the **Policy**.]

[Foreign National] means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]

Insured means an individual who is eligible for coverage under this **Policy** as provided in the Eligibility and Classification of Insureds part of the Schedule, and who completes the enrollment material, if required.

[Non-Contributory] means that the premium payments require no contribution from the **Insured**.]

[Past Member] means a member who is no longer active according to the rules of the **Policyholder**.]

[Physician] means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not **Related** to **You** by blood or marriage.]

[Plan] means the coverages and/or benefits selected in the Schedule.]

Policy means this Group Accident Insurance Policy.

Policyholder means the group named in the Schedule.

Principal Sum means the amount of insurance applicable to the **Insured** [or **Covered Person**] as stated in the Schedule.

[Related] means [**Your Spouse**]/**Domestic Partner**] or other adult living with **You**] [the **Insured's Spouse**]/**Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.]

[Retiree] means a former employee of the **Policyholder**:

1. [whose age plus years of service equals at least [60-70];]

2. [who has attained the normal retirement age;]
3. [who has completed at least [1-10] years of active full-time or part-time service with the **Policyholder**;]
4. [who is participating in a **Policyholder**-sponsored pension plan;][or]
5. [who retired from the **Policyholder** immediately after the last day as an **Active Employee**.]

[Service Waiting Period] means the continuous length of time a person is required to be [employed][a member][by][of] the **Policyholder** prior to being covered under this **Policy**.]

Sponsor means **Policyholder**.

Spouse means the **Insured's** legally married **Spouse** [under age 70]. [A **Spouse** will only be a covered **Spouse** if a **Plan** covering the **Insured's Spouse** is selected.]

We, Us, and Our refers to Zurich American Insurance Company or **Our** authorized representative.

[You or Your] means the **Insured** to whom a **Certificate** is issued.]

SECTION IV – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. [suicide or any attempt at suicide or intentionally self-inflicted **Covered Injury** or any attempt at intentionally self-inflicted injury [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation.]
2. [war or any act of war, whether declared or undeclared.]
3. [involvement in any type of active military service [Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31) consecutive days].];][For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.][This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.]
4. [illness or disease [, regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods].]
5. [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot].]
6. [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity].]
7. [being intoxicated while operating a motor vehicle.][being intoxicated.]
 - a. A **Covered Person** [An **Insured**] will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the [**Covered Person's**] [**Insured's**] intoxication.]
8. [being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]
9. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
10. [release[,whether or not **Accidental**, or by any person unlawfully or intentionally,] of nuclear energy or radiation, including sickness or disease resulting from such release.]
11. [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**.]
12. [alcoholism, drug addiction or the use of any drug or controlled substance except as prescribed by a licensed medical provider operating within his or her scope of authority.]
13. [participation in any team sport or any other athletic activity.]

14. [any condition for which the **Insured** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]
15. [the **Insured** riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]
16. [any loss incurred while outside the United States, its territories or Canada.]

SECTION V – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If [a **Covered Person**] [an **Insured**] suffers more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Coverages and Benefits. If [a **Covered Person**] [an **Insured**] can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule, as a result of the same **Accident**, the most **We** will pay for these benefits in total is the [**Covered Person's**] [**Insured's**] **Principal Sum**.

SECTION VI – PREMIUMS

- A. Premiums. Premiums are due and payable to **Us** at the rates and in the manner described in the [Schedule][Policyholder Application]. All rates are expressed and all premiums are payable in United States currency. If, at any time, it is determined that additional premium or a premium credit is due, the **Policyholder** will pay the additional premium or apply the premium credit at the next premium due date. Except in the case of fraud, premium adjustments will be made only for the current Policy Period and the prior Policy Period.
- B. Grace Period. Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If the **Policyholder** does not pay a renewal premium when it is due, there is a [thirty-one (31)] day Grace Period to pay. During the Grace Period, the **Policy** will stay in force. The **Policyholder** will not have a Grace Period if **We** have given notice, at least [thirty (30)] days in advance, that **We** are going to terminate this **Policy**.
- C. Change in Premium. **We** may change the premium as a condition of any renewal of this **Policy** by giving [at least [31] days] written notice to the **Policyholder**. **We** may also change premium at any time when any change, agreed upon in writing, between the **Policyholder** and **Us** is made that affects coverage or if it is discovered that there was a material misrepresentation in the information relied upon in establishing the premiums.

SECTION VII - TERMINATION OF INSURANCE

- A. Policy Renewal and Termination.

Renewal. This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent to terminate as specified herein.

Termination by Policyholder. The **Policyholder** may terminate this **Policy** on the first renewal date or at any time after that date by delivering to **Us** a written notice to end this **Policy** at least [thirty (30)] days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

Termination by Us. **We** may terminate this **Policy** by giving the **Policyholder** at least [thirty (30)] days notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** may also end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

We may also, at any time, end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records. Termination will be without prejudice to any claim which commenced prior to the effective date of termination.

- B. Termination of **Covered Person's** Insurance.

[**Insured**. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. the **Insured** ceases to be eligible for insurance;
3. the **Insured** fails to pay the required premium, if the **Insured** is so required;
4. [the **Insured** reaches age [70]];
5. [the **Insured** retires].]

[**Insured**. Insurance automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date the **Insured** ceases to be eligible for insurance;
3. the expiration date of the period for which required premium has been paid for such **Insured**;
4. the date the **Insured** fails to pay the required premium, if the **Insured** is so required;
5. [the date the **Insured** reaches age [70]];
6. [the date the **Insured** retires.]]

[If an **Insured** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written Policy, his or her insurance under this **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this **Policy** with the exception of number 2. above.]

[**Covered Person** other than the **Insured**. Insurance terminates on the earliest of:

1. the date the insurance of the **Insured** terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**;
3. [for the **Covered Spouse[/Domestic Partner]**, the date the **Covered Spouse[/Domestic Partner]** reaches age [70].]]

SECTION VIII - HOW TO FILE A CLAIM

- A. Notice. The **Insured** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within [ninety (90)] days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name [the **Covered Person** who sustained the injury,] the **Insured**, and the Policy Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact **Us** at [1-866-841-4771.] The notice must be sent to the address shown on the Schedule, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.
- B. Claim Forms. **We** will send the claimant Proof of Covered Loss forms within [fifteen (15)] days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss form in [fifteen (15)] days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.
- C. Proof of Covered Loss. Written Proof of Covered Loss, acceptable to **Us**, must be sent within [ninety (90)] days of the **Covered Loss**. Failure to furnish Proof of Covered Loss acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.

SECTION IX - PAYMENT OF CLAIMS

- A. Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the Proof of Covered Loss that is acceptable to **Us**.
- B. Who We Will Pay.
 1. Loss of life of an **Insured**. **Covered Losses** resulting from the **Insured's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same

time as the **Insured**, **We** will pay the benefit to [the beneficiary named by the **Insured** for the **Insured's** Life Insurance policy. If there is no beneficiary named by the **Insured** for the **Insured's** Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to] [the **Insured's** survivors in the following order:

- a. the **Insured's Spouse[/Domestic Partner]**;
 - b. the **Insured's** child(ren);
 - c. the **Insured's** parents;
 - d. the **Insured's** brothers and sisters;
 - e. the **Insured's** estate.
2. All Other Claims. Benefits are to be paid to the **[Covered Person][Insured]**. [He or she may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the **[Covered Person][Insured]** at any time up to the filing of the Proof of Covered Loss].
3. [If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]
4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

SECTION X - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** The **Insured** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. Unless an irrevocable beneficiary is named, The **Insured** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed. Any beneficiary designation must be in writing on a form acceptable to **Us**.
- B. Change or Waiver.** A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.
- C. Clerical Error.** A clerical error or omission will not increase or continue an **Insured's** coverage, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. Conformity with Statute.** Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.
- E. Entire Contract.** This **Policy**, the **Policyholder** application, **Insured** enrollment materials, Benefit Riders, and any other attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. Insured Certificates.** **We** will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Insureds**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insureds**. Such **Certificate** will contain a summary of terms that affect benefits.
- G. Suit Against Us.** No action on this **Policy** may be brought until sixty (60) days after written Proof of Covered Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Covered Loss was required to be submitted. If the law of the state where the **[Covered Person] [Insured]** lives makes such limit void, then the action

must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

- H. Physical Examination and Autopsy. **We** have the right to examine [a **Covered Person**] [an **Insured**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- I. Policyholder Records. The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.]
- J. [Reduction Schedule. [At age [70], [for the **Insured** only,] the **Principal Sum** will be reduced based on the [**Covered Person's**] [**Insured's**] previous **Principal Sum** per the following schedule shown below for **Your** attained age:

Age at Date of Loss	Percent of Original Principal Sum
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if:

1. **You** become covered under the **Policy**; or
 2. **Your** coverage increases;
 3. On or after the date **You** attain age [70].]
- K. [Choice of Service Provider. The [**Covered Person**] [**Insured**] has the sole right to choose his or her duly licensed **Physician** and hospital.]
- L. [Arbitration. Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the [**Covered Person**] [**Insured**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the [**Covered Person**] [**Insured**] is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the [**Covered Person**] [**Insured**].]
- M. Time Limit on Certain Defenses. In the absence of fraud, statements made by the **Policyholder** or [an **Insured**] [a **Covered Person**] are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under this **Policy** or be used as a defense of a claim, unless it is contained in a written application signed by the **Policyholder** or the [**Insured**] [**Covered Person**], a copy of which has been furnished to the **Policyholder** or to the person or his or her beneficiary. After two years from the date coverage starts no such statement (except age) will cause this **Policy** to be contested.
- N. **New Entrants.** All new [employees] [members] in the groups or classes eligible for insurance under the **Policy** will be added to such eligible groups or classes from time to time.

SECTION XI – COVERAGES

[[**ACCIDENTAL DEATH [AND DISMEMBERMENT]]**COVERAGE

If [a **Covered Person**] [an **Insured**] [or a covered **Spouse** [/**Domestic Partner**]] [suffers a loss of life as a result of a **Covered Injury**], **We** will pay the applicable **Principal Sum**. The death must occur within [365] days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] [an **Insured**] [or a covered **Spouse**[/**Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. Both Hands or Both Feet	[100% of Principal Sum]
2. One Hand and One Foot	[100% of Principal Sum]
3. One Hand or One Foot plus the loss of Sight of One Eye	[100% of Principal Sum]
4. Sight of Both Eyes	[100% of Principal Sum]
5. Speech and Hearing	[100% of Principal Sum]
6. Speech or Hearing	[50% of Principal Sum]
7. One Hand; One Foot; or Sight of One Eye	[50% of Principal Sum]
8. Thumb and Index Finger of the same Hand	[25% of Principal Sum]
9. Hearing in One Ear	[25% of Principal Sum]

For purposes of this benefit:

Covered Loss means:

1. For a foot or hand, actual severance through or above an ankle or wrist joint;
2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.]

[EXPOSURE AND DISAPPEARANCE COVERAGE]

If [a **Covered Person**] [an **Insured**] is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [a **Covered Person**] [an **Insured**] is riding disappears, is wrecked, or sinks, and the [**Covered Person**] [**Insured**] is not found within [365 days] of the event, **We** will presume that the person lost his or her life as a result of injury. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the [**Covered Person**] [**Insured**] survived the event.]]

SECTION XII – IMPORTANT NOTICE

The [**Insured**] [**Covered Person**] may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the [**Insured**] [**Covered Person**] can write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should the [**Insured**] [**Covered Person**] wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the [**Insured**] [**Covered Person**] may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

Application

Group Accident Insurance



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

APPLICANT INFORMATION

Applicant's Legal Name: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: _____ Facsimile: _____ Website: _____
Contact Person: _____ Email: _____
Are Subsidiaries/Affiliates to be covered? ☐ Yes ☐ No If Yes, please provide a list of complete names and addresses of all to be covered.
Requested Policy Inception Date: _____ Policy Number: _____

PRODUCER INFORMATION

Agent or Broker Name: _____ Name of Firm: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: _____ Facsimile: _____ Email: _____
Producer Number: _____ Commission: ☐ Yes ☐ No If Yes, _____% requested

INSURANCE REQUESTED

A. ELIGIBILITY AND CLASSIFICATION OF INSURED(S): [Total Number Eligible:]

Class I: [[Active Employees working a minimum of [15 hours] per week] [Active Members] _____
[Class II: [Retirees], [Past Members]] _____
[Class III: [[Dependents.]]] _____

Foreign Nationals Included? ☐ Yes ☐ No

Dependent Coverage? ☐ Yes ☐ No

[Service Waiting Period: [[30 days] of Active continuous service.]]

B. PRINCIPAL SUM:

Class I: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].

[Class II: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].]

[Class III: []]

[The **Principal Sum** for Covered **Dependents** will be a percentage of the **Insured's Principal Sum**, as follows:

Plan Selected	% Spouse	
	[/Domestic Partner]	% Child(ren)
Spouse[/Domestic Partner] only:	[50%]	0%
Dependent Child(ren) only:	0%	[15%]
Spouse[/Domestic Partner] and Dependent Child(ren):	[40%]	[10%]

[Reduction of Principal Sum:

If [an **Insured**] [a **Covered Person**] is age [70] or older on the date of an a **Covered Accident** , the **Principal Sum** used to calculate benefits will be the following percentage of the applicable **Principal Sum** indicated above:

Age at Date of Accident	% of Original Principal Sum
[70 - 74]	[65%]
[75 - 79]	[45%]
[80 - 84]	[30%]
[85] and Older	[15%]

C. COVERAGES:

Coverage	Class Covered	Coverage Amount
[Accidental Death [and Dismemberment] Coverage]	[All]	[Accidental Death [100% of Principal Sum]]
		[Loss of:
		1. Both Hands or Both Feet [100% of Principal Sum]
		2. One Hand and One Foot [100% of Principal Sum]
		3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum]
		4. Sight of Both Eyes [100% of Principal Sum]
		5. Speech and Hearing [100% of Principal Sum]
		6. Speech or Hearing [50% of Principal Sum]
		7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum]
		8. Thumb and Index Finger of the same Hand [25% of Principal Sum]
		9. Hearing in One Ear [25% of Principal Sum]
[Exposure and Disappearance Coverage]	[All]	[100% of Principal Sum]
[]	[All]	[]

D. BENEFIT RIDER(S):

Benefit	Class Covered	Benefit Amount	Form Number
[[Higher] Education Benefit]	[All]	[[10%] of the [Covered Person's] [Insured's] Principal Sum] [Up to [\$10,000] per [Covered] Dependent Child]	[U-GMC-]
[Common Carrier Benefit]	[All]	[\$50,000] [[\$50,000] or Up to a maximum of [50%] of the [Covered Person's] [Insured's] Principal Sum]	[U-GMC-]
[Common Disaster Benefit]	[All]	[\$500,000]	[U-GMC-]
[Carjacking Benefit]	[All]	[[10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]	[U-GMC-]
[Felony Assault Benefit]	[All]	[15%] of the Insured's Principal Sum	[U-GMC-]

[Identity Theft Resolution Services]	[All]	[Identity Theft Resolution Services]	[U-GMC-]
[Rehabilitation Benefit]	[All]	[[10%] of the Covered Person's Insured's Principal Sum or to a maximum of [\$10,000] [\$10,000]	[U-GMC-]
[Seat Belt/[Air Bag] Benefit]]	[All]	[Seat Belt - [10%] of the Principal Sum to a maximum of [\$10,000] [\$10,000] [Air Bag - [10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]	[U-GMC-]
[]	[All]	[]	[U-GMC-]]

E. [[AGGREGATE] LIMIT OF LIABILITY [for air travel] [\$5,000,000] per Covered Accident]]

F. PREMIUMS:

Due Date: [First day of each month] [Policy Inception Date]

Amount Due:

[[Active Member][Active Employee] [Only]:	[\$0.000] per \$[1,000] of Principal Sum per month]
[Spouse[/Domestic Partner] Only:	plus [\$0.000] per \$[1,000] of Principal Sum per month]
[Dependent Child(ren) Only:	plus [\$0.000] per \$[1,000] of Principal Sum per month]
[Spouse[/Domestic Partner] and Dependent Child(ren):	plus [\$0.000] per \$[1,000] of Principal Sum per month]

[Annual Premium Option: [\$10,000]

[These rates are][This **Policy** is] guaranteed until [January 1, 2009].]

[These rates and this **Policy** are guaranteed until [January 1, 2009].]

INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The applicant hereby applies for Group Accident Insurance and declares that:

All information provided in this application and any attachments hereto is true and correct. The undersigned understands that all information provided in this application and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium;
2. the insurance under the policy begins on the Policy Inception Date shown above; and
3. the acceptance of the policy terminates any prior policy of the same policy number, effective with the inception of the policy.

This Application shall be made part of the **Policy**, if issued.

Completed by: _____

Title: _____

Signature: _____

Date: _____

Signed at: _____

Date: _____

Group Accident Insurance Certificate



ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in Section I - Schedule of Benefits and Coverages and if the required premiums are paid when due.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

**THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE [ONLY]
[THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS]**

**THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY
WHICH APPLY TO YOU.**

**FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE
POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE
POLICY FROM THE POLICYHOLDER.**

**THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS
BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN**

.PLEASE READ THIS CERTIFICATE CAREFULLY

NON-PARTICIPATING

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SECTION I - SCHEDULE

- I. **POLICYHOLDER:** [John Doe Corporation]
[123 Main Street]
[Anywhere, XX 10011]
[COVERED SUBSIDIARIES OR AFFILIATED COMPANIES: [ABC Company]]
- II. **POLICY NUMBER:** [ABC-1234567]
- III. **POLICY INCEPTION DATE:** [January 1, 2010]
- IV. **POLICY PERIOD:** [Effective Date] to [Expiration Date] [Continuous]
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)
- V. **INSURED:** [Insured's Name]
[Street Address]
[City, State Zip]
- VI. **CERTIFICATE NUMBER:** [XXXXXXX-XX]
- VII. **COVERED DEPENDENTS:** [Spouse's/Domestic Partner's] Name]
[Dependent Child(ren)'s Name(s)]
- VIII. **PREMIUM:** [\$00.00] Payable [Monthly]
- IX. **ELIGIBILITY AND CLASSIFICATION OF INSUREDS:**

The following individuals are eligible to become **Insureds** upon [completion of the **Service Waiting Period** as indicated below, and] the submission of completed enrollment material, if required:

Class I: [Active Employees working a minimum of [15 hours] per week.] [Active Members]

[Class II: [Retirees] [Past Members]]

[Class III: [Dependents]]

If a **Covered Person** suffers a **Covered Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

[SERVICE WAITING PERIOD:

[[30 days] of **Active** continuous service.]]

[X]. **PRINCIPAL SUM:**

Class I: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].

[Class II: [An [employee] [member] may purchase an amount of **Principal Sum** from a minimum of [\$1,000] to a maximum of [\$50,000,000].]]

[The **Principal Sum** for covered **Dependents** will be a percentage of the **Insured's Principal Sum**, on the date of **Accident**, determined by multiplying **Your Principal Sum** by the percentage below.

<u>Plan Selected</u>	<u>% Spouse[/Domestic Partner]</u>	<u>% Child(ren)</u>
Spouse[/Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and Dependent Child(ren) ;	[40%]	[10%]

[XI]. [[**AGGREGATE**] **LIMIT OF LIABILITY** [for air travel] [\$5,000,000] per **Covered Accident**

[If the total of all benefits payable for all **Covered Persons** per **Accident**, in the absence of this provision exceeds the above amount, each benefit amount will be proportionately reduced so that the total will equal the above amount.]

[If both **Non-Contributory** and **Contributory** coverage are included, the above list of benefits will be labeled **Non-Contributory** and then the benefits applicable to the **Contributory** coverage will be listed below.]

Benefits payable under any attached Riders are subject to the **[Aggregate] Limit of Liability.**]

[XII]. COVERAGES:

COVERAGE	CLASS COVERED	COVERAGE AMOUNT
[Accidental Death [and Dismemberment] Coverage]]	[All]	[Accidental Death [100% of Principal Sum]]
		[Loss of:
		1. Both Hands or Both Feet [100% of Principal Sum]
		2. One Hand and One Foot [100% of Principal Sum]
		3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum]
		4. Sight of Both Eyes [100% of Principal Sum]
		5. Speech and Hearing [100% of Principal Sum]
		6. Speech or Hearing [50% of Principal Sum]
		7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum]
		8. Thumb and Index Finger of the same Hand [25% of Principal Sum]
		9. Hearing in One Ear [25% of Principal Sum]]
[Exposure and Disappearance Coverage]	[All]	[100% of Principal Sum]
[]	[All]	[]

[[XIII]. BENEFIT[S] RIDER[S]:

BENEFIT	CLASS COVERED	BENEFIT AMOUNT	FORM NUMBER
[[Higher] Education Benefit]]	[All]	[[10%] of the [Covered Person's] [Insured's] Principal Sum] [Up to [\$10,000] per [Covered] Dependent Child]	[U-GMC-]
[Common Carrier Benefit]	[All]	[\$50,000] [[50,000] or Up to a maximum of [50%] of the [Covered Person's] Principal Sum]	[U-GMC-]
[Common Disaster Benefit]	[All]	[\$500,000]	[U-GMC-]
[Carjacking Benefit]	[All]	[[10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]	[U-GMC-]
[Felonious Assault Benefit]	[All]	[15%] of the Insured's Principal Sum	[U-GMC-]
[Identity Theft Resolution Services]	[All]	[Identity Theft Resolution Services]	[U-GMC-]
[Rehabilitation Benefit]	[All]	[[10%] of the [Covered Person's] [Insured's] Principal Sum or to a maximum of [\$10,000] [\$10,000]	[U-GMC-]

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

[ELIGIBILITY OF INSURED'S DEPENDENTS

You may elect to cover **Your** eligible **Dependents**. An eligible **Dependent** includes **Your Spouse[/Domestic Partner]** and **Your Dependent Child(ren)**, [and] **[Your Spouse's Dependent Child(ren)]** [, and **Your Domestic Partner's Dependent Child(ren)**]. A **Spouse[/Domestic Partner]** will not be eligible as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your Spouse[/Domestic Partner]**, or former **Spouse[/Domestic Partner]** are both **Insured's** under the **Policy**, only one may select a **Plan** covering **Your** mutual **Dependents**.]

INSURED'S EFFECTIVE DATE

Your coverage under the **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the date for which the first premium for **Your** coverage is paid;
3. the date **You** become a member of an eligible class of persons as described in the Eligibility and Classification of Insureds section of the **Policy**; or
4. [[A. For individuals eligible on [Date]: provided the completed enrollment material is received by **Us** on or prior thereto.]
[B. For individuals eligible on or after [Policy Inception]: [[on the first day of the month following] the date the completed enrollment material is received by **Us**.]] [upon] [on the first day of the month following] completion of the required **Service Waiting Period** indicated above, provided the completed enrollment material is received by **Us** prior thereto.]]

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class becomes effective on the later of:

1. when the change in **Your** eligible class occurs; or
2. if the change requires a change in premium, the date the first changed premium is paid.

However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

[ELIGIBLE DEPENDENTS EFFECTIVE DATE

An eligible **Dependent's** coverage under the **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. **Your** Effective Date;
3. the date for which the first premium for the **Dependent's** coverage is paid;
4. the date the person qualifies as a **Dependent**; or
5. [the date on which written enrollment for the **Dependent** is received by **Us**.]

[**Your** child born while the **Policy** is in force is covered from the moment of birth for a period of 60 days. **Your** adopted newborn child is covered from the moment of birth for a period of 60 days. After this time, **Your** child will remain covered only if **You** have provided written notice of birth or the filing of a petition for adoption to the **Policyholder** and pays the required premium due, if any.]

[**Your** newly adopted child is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 60 days. After this time, **Your** child will remain covered only if **You** have provided written notice to the **Policyholder** of the adoption or the filing of a petition for adoption, and pay the required premium due, if any.]

SECTION III – DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

[**Active** means [a member as defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.].]

[**Active** and **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.]

[**Active Employee** means any natural persons in the regular service of the **Policyholder** and in the ordinary course of the **Policyholder's** business.]

[**Active Member** means a member in good standing according to the rules of the **Policyholder**.]

[[**Aggregate**] **Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the [**Aggregate**] **Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [1] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the [**Aggregate**] **Limit of Liability** is not enough to pay full benefits to each [**Covered Person**] [**Insured**], **We** will pay each one a reduced benefit based upon the proportion that the [**Aggregate**] **Limit of Liability** bears to the total benefits which would otherwise be paid.]

Certificate means this Group Accident Insurance Certificate.

[**Contributory** means that the premium payments require that **You** pay all or a portion of the premium.]

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Injury means bodily injury directly caused by **Accidental** means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under the **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You** [,and **Your Spouse**]/**Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering **Your Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** is selected.]

Dependent means **Your Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this section. [**Your Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.]

Dependent Child(ren) means **Your** unmarried **Child(ren)**, [and] [those unmarried **Child(ren)** of **Your Spouse**]/**Domestic Partner**]] [, and those unmarried **Child(ren)** [as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**] who rely on **You** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [**Your Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.]

[**Domestic Partner** means [a person who qualifies as a **Domestic Partner** under the **Policyholder's** written procedures as on file and approved by **Us**.] [a person who qualifies as a **Domestic Partner** under the law of the state of residence.] [as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**.]]

To qualify as a **Domestic Partner**, the following requirements must be met:

1. [**You** and **Your Domestic Partner** must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]
2. [**You** and **Your Domestic Partner** must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]
3. [**You** and **Your Domestic Partner** must both be at least 18 years of age;]
4. [neither **You** nor **Your Domestic Partner** are legally married;]
5. [**You** and **Your Domestic Partner** are not **Related** by blood or adoption;]
6. [**You** and **Your Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely;]
[and]

7. [You and Your Domestic Partner must be of the same sex, and if applicable law permitted, would be married.]

The existence of the relationship between **Your Domestic Partner** and **You** must be evidenced by:

1. [Your Domestic Partner being named as the primary beneficiary in the event of Your death under Your retirement plan or 401(k) plan, if You maintain such a plan;]
2. [at least one of the following:
 - a. designation of Your Domestic Partner as a primary beneficiary under Your will; or
 - b. designation of Your Domestic Partner as a primary beneficiary for Your life insurance;]
3. [at least one of the following:
 - a. joint ownership of real estate (whether by mortgage, lease or deed);
 - b. joint ownership of a motor vehicle; or
 - c. joint ownership of a bank account; and]
4. [a completed, active certification of Domestic Partner status form on file with the Policyholder.]

To be active, **You** will not have completed a Termination of Domestic Partner status form with respect to **Your Domestic Partner** who is to be covered under the **Policy**.]

Foreign National means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]

Insured means an individual who is eligible for coverage under the **Policy** as provided in the Eligibility and Classification of Insureds part of the Schedule, and who completes the enrollment material, if required.

[Non-Contributory means that the premium payments require no contribution from **You**.]

[Past Member means a member who is no longer active according to the rules of the **Policyholder**.]

[Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not **Related** to **You** by blood or marriage.]

[Plan means the coverages and/or benefits selected in the Schedule.]

Policy means the Group Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the group named in the Schedule.

Principal Sum means the amount of insurance applicable to the **Insured** [or **Covered Person**] as stated in the Schedule.

[Related means [Your Spouse[/Domestic Partner] or other adult living with You], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.]

[Retiree means a former employee of the **Policyholder**:

1. [whose age plus years of service equals at least [60-70];]
2. [who has attained the normal retirement age;]
3. [who has completed at least [1-10] years of active full-time or part-time service with the **Policyholder**;]
4. [who is participating in a **Policyholder**-sponsored pension plan;][or]
5. [who retired from the **Policyholder** immediately after the last day as an **Active Employee**.]

[Service Waiting Period means the continuous length of time a person is required to be [employed][a member][by][of] the **Policyholder** prior to being covered under the **Policy**.]

Sponsor means **Policyholder**.

Spouse means **Your** legally married **Spouse** [under age 70]. [A **Spouse** will only be a covered **Spouse** if a **Plan** covering **Your Spouse** is selected.]

We, Us, and Our refers to Zurich American Insurance Company or **Our** authorized representative.

You or Your means the **Insured** to whom a **Certificate** is issued.

SECTION IV – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. [suicide or any attempt at suicide or intentionally self-inflicted **Covered Injury** or any attempt at intentionally self-inflicted injury [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation].]
2. [war or any act of war, whether declared or undeclared.]
3. [involvement in any type of active military service [Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31) consecutive days].];[For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.][This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.]
4. [illness or disease [, regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods].]
5. [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot].]
6. [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity].]
7. [being intoxicated while operating a motor vehicle.][being intoxicated.]
 - a. A **Covered Person [You]** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of [the **Covered Person's**] [**Your**] intoxication.]
8. [being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]
9. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
10. [release[,whether or not **Accidental**, or by any person unlawfully or intentionally,] of nuclear energy or radiation, including sickness or disease resulting from such release.]
11. [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**.]
12. [alcoholism, drug addiction or the use of any drug or controlled substance except as prescribed by a licensed medical provider operating within his or her scope of authority.]
13. [participation in any team sport or any other athletic activity.]
14. [any condition for which **You** are entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]
15. [riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]
16. [any loss incurred while outside the United States, its territories or Canada.]

SECTION V – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If [a **Covered Person** suffers] **[You suffer]** more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Coverages and Benefits. If [a **Covered Person**] **[You]** can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule, as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **[Covered Person's] [Your] Principal Sum**.

SECTION VI – PREMIUMS

- A. Premiums.** Premiums are due and payable to **Us** at the rates and in the manner described in the Schedule.
- B. Grace Period.** Premiums are due on or before the premium due date or renewal date, whichever applies. If **You** do not pay premium when it is due, there is a [thirty-one (31)] day Grace Period to pay. During the Grace Period, **Your** coverage under the **Policy** will stay in force.

SECTION VII - TERMINATION OF INSURANCE

- A. Termination of Covered Person's Insurance.**

[Insured. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;
4. **[You reach age [70]]**;
5. **[You retire].]**

[Insured. Insurance automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date **You** cease to be eligible for insurance;
3. the expiration date of the period for which required premium has been paid for **You**;
4. the date **You** fail to pay the required premium, if **You** are so required;
5. **[the date You reach age [70]]**;
6. **[the date You retire.]]**

[If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written Policy, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.]

[Covered Person other than the **Insured**. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**;
3. **[for Your Covered Spouse/[Domestic Partner], the date Your Covered Spouse/[Domestic Partner] reaches age [70].]**

SECTION VIII - HOW TO FILE A CLAIM

- A. Notice.** **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within [ninety (90)] days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name [the **Covered Person** who sustained the injury,] **You**, and the Policy Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at [1-866-841-4771.] The notice must be sent to the address shown on the Schedule, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

- B. Claim Forms.** **We** will send the claimant Proof of Covered Loss forms within [fifteen (15)] days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss form in [fifteen (15)] days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.
- C. Proof of Covered Loss.** Written Proof of Covered Loss, acceptable to **Us**, must be sent within [ninety (90)] days of the **Covered Loss**. Failure to furnish Proof of Covered Loss acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.

SECTION IX - PAYMENT OF CLAIMS

- A. Time of Payment.** **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the Proof of Covered Loss that is acceptable to **Us**.
- B. Who We Will Pay.**
1. Loss of **Your** life. **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to [the beneficiary named by **You** for **Your** Life Insurance policy. If there is no beneficiary named by **You** for **Your** Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to] [**Your** survivors in the following order:
 - a. **Your Spouse[/Domestic Partner];**
 - b. **Your** child(ren);
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
 2. All Other Claims. Benefits are to be paid to [the **Covered Person**][**You**]. [The **Covered Person**][**You**] may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by [the **Covered Person**][**You**] at any time up to the filing of the Proof of Covered Loss].
 3. [If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]
 4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

SECTION X - GENERAL POLICY CONDITIONS

- A. Beneficiaries.** **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. Unless an irrevocable beneficiary is named, **You** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed. Any beneficiary designation must be in writing on a form acceptable to **Us**.
- B. Change or Waiver.** A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A

failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

- C. Clerical Error. A clerical error or omission will not increase or continue **Your** coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of Covered Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Covered Loss was required to be submitted. If the law of the state where [the **Covered Person** lives] [**You** live] makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- E. Physical Examination and Autopsy. **We** have the right to examine [a **Covered Person**] [**You**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- F. [Reduction Schedule. [At age [70], [for **You** only,] the **Principal Sum** will be reduced based on [the **Covered Person's**] [**Your**] previous **Principal Sum** per the following schedule shown below for **Your** attained age:

Age at Date of Loss	Percent of Original Principal Sum
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if:

- 1. **You** become covered under the **Policy**; or
 - 2. **Your** coverage increases;
 - 3. On or after the date **You** attain age [70].]
- G. [Choice of Service Provider. [The **Covered Person** has] [**You** have] the sole right to choose [his or her] [**Your**] duly licensed **Physician** and hospital.]
 - H. [Arbitration. Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to [the **Covered Person**] [**You**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if [the **Covered Person** is] [**You** are] a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by [the **Covered Person**] [**You**].
 - I. Time Limit on Certain Defenses. In the absence of fraud, statements made by the **Policyholder** or [**You**] [a **Covered Person**] are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under the **Policy** or be used as a defense of a claim, unless it is contained in a written application signed by the **Policyholder** or [**You**] [the **Covered Person**], a copy of which has been furnished to the **Policyholder** or to **You** or **Your** beneficiary [or to the **Covered Person** or his or her beneficiary]. After two years from the date coverage starts no such statement (except age) will cause the **Policy** to be contested.
 - J. **New Entrants.** All new [employees] [members] in the groups or classes eligible for insurance under the **Policy** will be added to such eligible groups or classes from time to time.

SECTION XI – COVERAGES

[[ACCIDENTAL DEATH [AND DISMEMBERMENT]]COVERAGE

If [a **Covered Person**] [**You**] [or **Your** covered **Spouse** [/Domestic Partner]] [suffers a loss of life as a result of a **Covered Injury**], **We** will pay the applicable **Principal Sum**. The death must occur within [365] days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] [**You**] [or **Your** covered **Spouse**[/**Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. Both Hands or Both Feet	[100% of Principal Sum]
2. One Hand and One Foot	[100% of Principal Sum]
3. One Hand or One Foot plus the loss of Sight of One Eye	[100% of Principal Sum]
4. Sight of Both Eyes	[100% of Principal Sum]
5. Speech and Hearing	[100% of Principal Sum]
6. Speech or Hearing	[50% of Principal Sum]
7. One Hand; One Foot; or Sight of One Eye	[50% of Principal Sum]
8. Thumb and Index Finger of the same Hand	[25% of Principal Sum]
9. Hearing in One Ear	[25% of Principal Sum]

For purposes of this benefit:

Covered Loss means:

1. For a foot or hand, actual severance through or above an ankle or wrist joint;
2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.]

[EXPOSURE AND DISAPPEARANCE COVERAGE]

If [a **Covered Person** is] [**You** are] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [a **Covered Person** is] [**You** are] riding disappears, is wrecked, or sinks, and [the **Covered Person** is] [**You** are] not found within [365 days] of the event, **We** will presume that [the person lost his or her] [**You** lost **Your**] life as a result of injury. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that [the **Covered Person**] [**You**] survived the event.]]

SECTION XII – IMPORTANT NOTICE

You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You can write to Zurich American Insurance Company at their administrative offices at [XXXXXX].

Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

Blank Endorsement



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS ENDORSEMENT CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

[This endorsement will be used to make the following changes to the **Policy/Certificate**, which are administrative in nature: (1) changes to the Schedule; (2) addition or deletion of a subsidiary or affiliates of the **Policyholder**; (3) changes to the classes of covered persons; (4) annual audit requirement; and (5) other administrative changes to the **Policy/Certificate**.]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

[Higher] Education Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If the **Insured** [or the **Insured's Spouse[/Domestic Partner]**][selects a **Plan** covering his or her **Dependent Child(ren)** and the **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death] Coverage**, **We** will pay an additional benefit for [higher] education expenses incurred for each **Dependent Child**.

[A **Dependent Child** is eligible for the **[Higher] Education Benefit** if on the date of the **Covered Accident**:

1. he or she is enrolled as a full-time **Student** in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Covered Accident**.]

The **[Higher] Education Benefit** will be equal to the amount shown on the Schedule per **Dependent Child**. [This amount will be paid annually for up to [four (4)] consecutive years if the **Dependent Child** continues his or her education. Before this benefit is paid each year, the **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of [higher] learning on a full-time basis.]

[If, at the time of the **Covered Accident**, a **Plan** covering the **Insured's Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [\$1,000] to the designated beneficiary.]

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Common Carrier Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [**Accidental Death [and Accidental Dismemberment]**] **Coverage**, **We** will pay an additional benefit equal to the amount in the Schedule, provided the [**Covered Person**] [**Insured**] suffers the **Covered Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Common Disaster Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** and his or her **Covered Spouse** **[/Domestic Partner]** are both eligible for **[Accidental Death] Coverage** as a result of **Covered Injuries** suffered in the same **Covered Accident** [and within [90 days] of such **Covered Accident**,] the **Principal Sum** that would have been payable because of the **Covered Spouse's** **[/Domestic Partner's] Accidental Death** will be increased to equal that payable for the **Covered Loss** of the **Insured**, provided [:the **Insured** and **Covered Spouse****[/Domestic Partner]** are survived by one or more **Covered Dependent Child(ren)**; and] the combined benefits of the **Insured** and the **Covered Spouse** **[/Domestic Partner]** are not more than the amount shown on the Schedule.

For purposes of this benefit only, the following definitions apply:

Covered Dependent Child(ren) means [an] eligible **Dependent Child(ren)** who has insurance under the terms of this rider.

Covered Spouse **[/Domestic Partner]** means an eligible **Spouse** **[/Domestic Partner]** who has insurance under the terms of this rider.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Carjacking Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [**Accidental Death [and Accidental Dismemberment]**] **Coverage**, as a direct result of a **Covered Accident** that occurs during a **Carjacking** of a private passenger vehicle that the [**Covered Person**] [**Insured**] was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to the amount shown on the Schedule.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24) hours] of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24) hours] or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit only, **Carjacking** means a person other than the [**Covered Person**] [**Insured**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Felonious Assault Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death [or Accidental Dismemberment]] Coverage** as a result of a violent or criminal act committed by someone other than the **Insured**, [a **Fellow Employee**] or a member of his or her **Family** or **Household**, **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this benefit only, the following definitions apply:

[Fellow Employee] means a person employed by the same employer as the **Insured** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

Family means the **Insured's** parent, stepparent, **Spouse[/Domestic Partner]** or former **Spouse[/Domestic Partner]**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

Household means a person who maintains residence at the same address as the **Insured**.

This benefit applies only to the crimes or attempted crimes considered to be a felony by the local jurisdiction.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Rehabilitation Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If the **[Insured][Covered Person]** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Dismemberment] Coverage**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2) years] from the date of the **Covered Accident** for the **Rehabilitation Training**; or
2. the maximum amount shown in the Schedule.

For this benefit only, the following definitions apply:

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a **Physician** that is approved by **Us** prior to the provision of services;
2. is required due to the **[Insured's][Covered Person's] Covered Injury**;
3. prepares the **[Insured][Covered Person]** for an occupation that he or she would not have engaged in except for the **Covered Injury**; and
4. is not the result of a **Pre-existing Condition**.

Pre-existing Condition means a condition for which a **Covered Person** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [6] months immediately preceding the **Covered Loss**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Seat Belt[/Air Bag] Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [**Accidental Death**][and **Dismemberment**] **Coverage**, and the **Covered Injury** which caused the **Accidental** death directly resulted from an automobile **Covered Accident**, **We** will pay an additional **Seat Belt Benefit**, which equals the amount shown in the Schedule, provided that the [**Covered Person**] [**Insured**] was:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the [**Covered Person's**] [**Insured's**] actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional **Air Bag Benefit** equal to the amount shown in the Schedule, will be paid if the [**Covered Person**] [**Insured**] was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the [**Covered Person's**] [**Insured's**] seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a **Seat Belt** [or **Air Bag**] **Benefit** to the [**Covered Person**] [**Insured**] that was driving either:

1. under the influence of alcohol:
 - a. A driver will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred;
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Identity Theft Resolution Services Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Group Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:

For a **Covered Person** who is the victim of **Identity Theft** while covered under this **Policy**, **We** will provide the **Covered Person** with access to **Identity Theft Resolution Services** provided by a consumer fraud specialist who will assist the **Covered Person** in the process of restoring their identity. Any act or series of acts committed by any one person or group of persons acting in concert or in which any one person or group of persons is concerned or implicated is considered to be one **Identity Theft**, even if a series of acts continues into a subsequent policy period.

IDENTITY THEFT RESOLUTION SERVICES EXCLUSIONS

We will not cover expenses under this additional benefit for any loss other than **Identity Theft Resolution Services**.

For purposes of this benefit only, the following definitions apply:

Identity Theft means the act of knowingly transferring or using, without lawful authority, a means of identification of a **Covered Person** with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of federal law or a felony under any applicable state or local law.

Identity Theft Resolution Services means the assistance of a personal advocate assigned to a **Covered Person** who is the victim of **Identity Theft** while covered under this **Policy**. It also includes ordering credit reports, alerting credit reporting agencies, providing credit and fraud monitoring, and preparing necessary documentation and letters.

Identity Theft Resolution Services will also include free **Identity Theft** monitoring services for a twelve (12) month period for any **Covered Person** who is the victim of **Identity Theft** while covered under this **Policy**. **Identity Theft Resolution Services** will also provide free **Identity Theft** monitoring services for a twelve (12) month period for any **Covered Person** who becomes incapacitated or deceased while covered under this **Policy**. The twelve (12) month period for providing **Identity Theft Resolution Services** will begin on the date **We** receive written notice, in accordance with the provisions of Section VIII of the **Policy**, that a **Covered Person** is either the victim of **Identity Theft**, has become incapacitated or is deceased. Incapacitated or incapacitation is defined as any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy/Certificate** to which it is attached.

Effective Date: _____ Attached to and forming a part of Policy/Certificate No. _____

Enrollment Form

Group Accident Insurance



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of Policyholder:	[Master Policy Number:]

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: XXX-XX-	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -
Requested Effective Date (MM/DD/YYYY):		[Certificate Number (assigned by the Company):]	

SPOUSE [or DOMESTIC PARTNER] INFORMATION (if Enrollee is applying for Dependent coverage)			
Full Legal Name (First, Middle Initial and Last):		Home Phone: - -	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		

DEPENDENT CHILD(REN) INFORMATION (if Enrollee is applying for Dependent coverage)		
Full Legal Name (First, Middle Initial and Last):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):
Full Legal Name (First, Middle Initial and Last):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):

INSURANCE REQUESTED	
Plan Selected (please check each box that applies):	Principal Sum (coverage amount)
<input type="checkbox"/> Enrollee	\$
<input type="checkbox"/> Spouse [or Domestic Partner] Only	[as per the Schedule]
<input type="checkbox"/> Dependent Child(ren) Only	[as per the Schedule]
<input type="checkbox"/> Spouse [or Domestic Partner] and Dependent Child(ren)]	[as per the Schedule]
[The Principal Sum for Covered Dependents will be a percentage of the Enrollee's Principal Sum .]	
[Coverage(s) Included:	Coverage Amount
[Accidental Death Coverage]	[as per the Schedule]

[Dismemberment Coverage]	[as per the Schedule]
[Exposure and Disappearance Coverage]	[as per the Schedule]
[]	[as per the Schedule]]
[Benefit(s) Included:	Benefit Amount
[[Higher] Education Benefit]	[as per the Schedule]
[Common Carrier Benefit]	[as per the Schedule]
[Common Disaster Benefit]	[as per the Schedule]
[Carjacking Benefit]	[as per the Schedule]
[Felonious Assault Benefit]	[as per the Schedule]
[Identity Theft Resolution Services]	[as per the Schedule]
[Rehabilitation Benefit]	[as per the Schedule]
[Seat Belt/[Air Bag] Benefit]	[as per the Schedule]
[]	[as per the Schedule]]

BENEFICIARY DESIGNATION		
Primary Beneficiary:		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
Contingent Beneficiary:		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

PREMIUM INFORMATION:	
Annual Premium: \$	Frequency of Payment: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly
Method of Payment: <input type="checkbox"/> Credit Card <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill The Enrollee must complete a separate authorization form for a Credit Card or Bank Draft payment.	

INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic):

Date:

[AGENT INFORMATION	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:]]

<i>SERFF Tracking Number:</i>	<i>ZURC-126394542</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>44163</i>
<i>Company Tracking Number:</i>	<i>CW AH 29266</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Group Accident Policy</i>		
<i>Project Name/Number:</i>	<i>/CW AH 29266</i>		

Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Approved-Closed	12/01/2009
Comments:		
Attachment:		
ZAIC Group Accident Form Filing Certificate of Readability with Enrollment Form.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved-Closed	12/01/2009
Comments:		
The Application is attached to the forms schedule tab		

	Item Status:	Status
		Date:
Satisfied - Item: Explanatory	Approved-Closed	12/01/2009
Comments:		
Attachment:		
AR U-GMC Explanatory Memorandum.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Statement of Variables	Approved-Closed	12/01/2009
Comments:		
Attachment:		
U-GMC Statement of Variables for Arkansas 11-19-09.pdf		

Certificate of Readability



Zurich American Insurance Company

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-GMC-100-A (08/09)	Group Accident Insurance Policy	54
U-GMC-101-A (08/09)	Application	61
U-GMC-102-A (08/09)	Group Accident Insurance Certificate	58
U-GMC-103-A (08/09)	Enrollment Form	55
U-GMC-104-A (08/09)	Blank Endorsement	43
U-GMC-110-A (08/09)	[Higher] Education Benefit	47
U-GMC-111-A (08/09)	Common Carrier Benefit	44
U-GMC-112-A (08/09)	Common Disaster Benefit	48
U-GMC-113-A (08/09)	Carjacking Benefit	41
U-GMC-114-A (08/09)	Felonious Assault Benefit	45
U-GMC-115-A (08/09)	Rehabilitation Benefit	43
U-GMC-116-A (08/09)	Seat Belt [Air Bag] Benefit	38
U-GMC-118-A (08/09)	Identity Theft Resolution Services Benefit	37

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature:

A handwritten signature in dark ink, appearing to read 'Lisa Plante', written over a horizontal line.

Officer:

Lisa Plante

Title:

Vice President, Accident & Health

Date:

November 20, 2009



Zurich American Insurance Company

**EXPLANATORY MEMORANDUM
Group Accident Insurance Policy
Company Filing Number – CW AH 29266
U-GMC-100-A (08/09), et al**

This is a new Group Accident Insurance product, which will be marketed to all statutorily eligible groups in your state consisting of two (2) or more individuals. Eligible groups shall include, but is not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.

This Group Accident Insurance product may be marketed through brokers, consultants, third party administrators and sales employees.

All forms are new and are not intended to replace any other forms currently in use.

The plan provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Coverage is offered on a contributory and non-contributory basis.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

This filing includes a certificate of readability and statement of variables.

Statement of Variables for Arkansas



GROUP ACCIDENT INSURANCE POLICY **U-GMC-100-A, et al**

This Policy has been developed for use as either a Basic or Voluntary Policy. In all cases where [an Insured] or [You] is bracketed, the Policy will be issued as a Basic Policy. In all cases where [a Covered Person] is bracketed, the Policy will be issued as a Voluntary Policy.

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted.) Each bracketed phrase will be in or out. Language concerning Non-Contributory coverage and Contributory coverage will be in or out. Language concerning Dependents will be included if Dependent coverage is included, otherwise omitted. Eligible persons and Classes will be as defined by the Policyholder. [Domestic Partner] will always be in or out.

GROUP ACCIDENT INSURANCE POLICY – U-GMC-100-A AR (08/09)

Face Page

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.] THIS GROUP ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE [ONLY] [THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS]	[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.] will be in or out. [ONLY] will be in or out. [THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS] will be in or out.
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SECTION I – SCHEDULE

POLICYHOLDER: [John Doe Corporation] [123 Main Street] [Anywhere, XX 10011] [COVERED SUBSIDIARIES OR AFFILIATED COMPANIES: [ABC Company]] POLICY NUMBER: [ABC-1234567] POLICY INCEPTION DATE: [January 1, 2010] POLICY PERIOD: [Effective Date] to [Expiration Date] [Continuous] CONTRACT SITUS: []	Name of the Policyholder will be inserted. Address of the Policyholder will be inserted. City, State and Zip Code of the Policyholder will be inserted. This will be in-or-out. If in, the Policyholder's subsidiaries or affiliated companies will be inserted. Policy number will be inserted. Policy Inception Date will be inserted. Effective Date will be inserted. Expiration Date will be in-or-out. If in, the Expiration Date will be inserted. Continuous will be in-or-out. State where Policy is issued will be inserted.
ELIGIBILITY AND CLASSIFICATION OF INSURED: [completion of the Service Waiting Period as indicated below, and] the submission of completed enrollment material, if required: Class I: [Active Employees working a minimum of [15 hours] per week.] [Active Members]	This will be in-or-out. Class definitions are variable and defined by the Policyholder based on elements relating to the relationship between the organization and its

<p>[Class II: [Retirees] [Past Members]]</p> <p>[Class III: [Dependents.]]</p>	<p>members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p> <p>[15 hours] The range will be 0 - 40</p> <p>If there is more than one Class eligible under the Policy a Schedule of Benefits may be presented for each Class if benefit applicability, amounts and duration differ by class or it may be presented in the aggregate.</p>
<p>[SERVICE WAITING PERIOD: [[30 days] of Active continuous service.]]</p>	<p>This provision will be in or out.</p> <p>The Service Waiting Period is variable and defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p> <p>[30 days] The range will be 0 – 120 days.</p>
<p>VII. PRINCIPAL SUM:</p> <p>Class I: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].</p> <p>[Class II: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].]]</p> <p>[The Principal Sum for covered Dependents will be a percentage of the Insured's Principal Sum, on the date of Accident, determined by multiplying Your Principal Sum by the percentage below.</p> <p>Plan Selected % Spouse[/Domestic Partner]% Child(ren)</p> <p>Spouse[/Domestic Partner] only: [50%]</p> <p>Dependent Child(ren) only: [15%]</p> <p>Spouse[/Domestic Partner] and Dependent Child(ren): [40%] [10%]</p>	<p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>This will be in for a Voluntary Policy only. If in:</p> <p>[50%] The range will be 25% - 100% [15%] The range will be 5% - 50%</p> <p>[40%] The range will be 25% - 100% [10%] The range will be 5% - 50%</p>
<p>VIII. [[AGGREGATE] LIMIT OF LIABILITY [for air travel] [\$5,000,000] per Covered Accident</p> <p>[If the total of all benefits payable for all Covered Persons per Accident, in the absence of this provision exceeds the above amount, each benefit amount will be proportionately reduced so that the total will equal the above amount.]</p> <p>[If both Non-Contributory and Contributory coverage are included, the above list of benefits will be labeled Non-Contributory and then the benefits applicable to the Contributory coverage will be listed below.]]</p> <p>Benefits payable under any attached Riders are subject to the [Aggregate] Limit of Liability.</p>	<p>This provision will be in or out. If in: [Aggregate] will be in or out; [for air travel] will be in or out; [\$5,000,000] The range will be \$1,000 - \$50,000,00;</p> <p>This will be in or out;</p> <p>This will be in or out;</p> <p>[Aggregate] will be in or out.</p>

<p>[[10%] of the [Covered Person's] [Insured's] Principal Sum or to a maximum of [\$10,000] [\$10,000]</p> <p>[Seat Belt/[Air Bag] Benefit] [Seat Belt - [10%] of the Principal Sum to a maximum of [\$10,000] [\$10,000]</p> <p>[Air Bag - [10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]</p> <p>[[]]</p>	<p>[10%] The range will be 1% - 100% [\$10,000] The range will be \$1,000 - \$50,000 [\$10,000] The range will be \$1,000 - \$50,000</p> <p>[10%] The range will be 5% - 50% [\$10,000] The range will be \$1,000 - \$100,000 [\$10,000] The range will be \$1,000 - \$100,000</p> <p>[10%] The range will be 5% - 50% [\$10,000] The range will be \$1,000 - \$100,000 [\$10,000] The range will be \$1,000 - \$100,000</p> <p>Additional Benefit Riders and benefit amounts may be added as filed and approved by the State.</p>
<p>XI. REPORTING AND NOTICE ADDRESSES:</p> <p>Claim Reporting: [Claims Department Zurich American Insurance Company, [P.O. Box 968041, Schaumburg, IL. 60196]] [1-866-841-4771]</p>	<p>This is variable in the event there is a change in the Company's mailing address and telephone number.</p>

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

<p>[ELIGIBILITY OF INSURED'S DEPENDENTS] Individuals who enroll may elect to cover their eligible Dependents. An eligible Dependent includes the Insured's Spouse/[Domestic Partner] and the Insured's Dependent Child(ren), [and] [his or her Spouse's Dependent Child(ren)] [, and his or her Domestic Partner's Dependent Child(ren)]. A Spouse/[Domestic Partner] will not be eligible as a Dependent if he or she is also an Insured under this Policy. If the Insured and his or her Spouse/[Domestic Partner], or former Spouse/[Domestic Partner] are both Insured's under this Policy, only one may select a Plan covering their mutual Dependents.]</p>	<p>This provision will be in or out.</p>
<p>INSURED'S EFFECTIVE DATE An Insured's coverage under this Policy begins on the latest of:</p> <p>4. [[A. For individuals eligible on [Date]: provided the completed enrollment material is received by Us on or prior thereto.]</p> <p>[B. For individuals eligible on or after [Policy Inception]: [[on the first day of the month following] the date the completed enrollment material is received by Us.]] [upon] [on the first day of the month following] completion of the required Service Waiting Period indicated above, provided the completed enrollment material is received by Us prior thereto.]]</p>	<p>This will be in or out. If in: [Date] will be determined by the Policyholder.</p> <p>This will be in or out. If in: [Policy Inception] Date will be inserted</p> <p>[[on the first day of the month following] the date the completed enrollment material is received by Us.]] will be in or out. If in: [on the first day of the month following] will be in or out [upon] will be in or out [on the first day of the month following] will be in or out</p>
<p>[ELIGIBLE DEPENDENTS EFFECTIVE DATE]</p>	<p>This provision will be in or out. If in:</p>

<p>An eligible Dependent's coverage under this Policy begins on the latest of:</p> <ol style="list-style-type: none"> 1. the Policy Inception Date shown in the Schedule; 2. the Insured's Effective Date; 3. the date for which the first premium for the Dependent's coverage is paid; 4. the date the person qualifies as a Dependent; or 5. [the date on which written enrollment for the Dependent is received by the Policyholder.] <p>[A child of an Insured born while this Policy is in force is covered from the moment of birth for a period of 60 days. An adopted newborn child of an Insured is covered from the moment of birth for a period of 60 days. After this time, the child will remain covered only if the Insured has provided written notice of birth or the filing of a petition for adoption to the Policyholder and pays the required premium due, if any.]</p> <p>[A newly adopted child of an Insured is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 60 days. After this time, the child will remain covered only if the Insured has provided written notice to the Policyholder of the adoption or the filing of a petition for adoption, and pays the required premium due, if any.]</p>	<p>This will be in or out;</p> <p>This will be in or out;</p> <p>This will be in or out.</p>
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SECTION III – DEFINITIONS

[Active] means [a member as defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc..]	This will be in or out. If in, Active will be defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.
[Active and Actively at Work] describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Actively at Work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.]	This will be in or out.
[Active Employee] means any natural persons in the regular service of the Policyholder and in the ordinary course of the Policyholder's business.]	This will be in or out.
[Active Member] means a member in good standing according to the rules of the Policyholder .]	This will be in or out.
[[Aggregate] Limit of Liability] means the total benefits We will pay for a Covered Accident or Covered Accidents set forth in the Schedule. For purposes of the [Aggregate] Limit of Liability provision, Covered Accident or Covered Accidents will include a Covered Loss or Covered Losses arising out of a single event or related events or originating cause [occurring within a [1] day period] and includes a resulting Covered Loss or Covered Losses . If the total benefits under the [Aggregate] Limit of Liability is not enough to pay full benefits to each [Covered Person] [Insured] , We will pay each one a reduced benefit based upon the proportion that the [Aggregate] Limit of Liability bears	<p>This definition will be in or out. If in:</p> <p>[Aggregate] will be in or out;</p> <p>[occurring within a [1] day period] will be in or out. If in:</p> <p>[1] The range will be 1 - 3 days</p>

to the total benefits which would otherwise be paid.]	
[Contributory] means that the premium payments require that the Insured pay all or a portion of the premium.]	This will be in or out.
Covered Person means any person who has insurance under the terms of this Policy . It includes the Insured . [,and his or her Spouse[/Domestic Partner] and/or Dependent Child(ren) if a Plan covering the Spouse [/Domestic Partner] and/or Dependent Child(ren) is selected.]	This section of the definition will be in or out.
Dependent means an Insured's Spouse [/Domestic Partner] and Dependent Child(ren) , as defined in this section. [The Dependent will only be a covered Dependent if a Plan covering Dependents is selected.]	This section of the definition will be in or out.
Dependent Child(ren) , if used in this Policy , means those unmarried Child(ren) of the Insured , [and] [those unmarried Child(ren) of his or her Spouse] [, and those unmarried Child(ren) [as defined in the Policyholder's [medical] plan as on file and approved by Us] [of the Insured's Domestic Partner] who rely on the Insured for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [The Dependent Child(ren) will only be covered Dependent Child(ren) if a Plan covering Dependent Child(ren) is selected.]	<p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>[19 (nineteen)] The range will be 18 - 30</p> <p>[25 (twenty-five)] The range will be 18 - 30</p> <p>This will be in or out.</p>
[Domestic Partner] means [a person who qualifies as a Domestic Partner under the Policyholder's written procedures as on file and approved by Us.] [a person who qualifies as a Domestic Partner under the law of the state of residence.] [as defined in the Policyholder's [medical] plan as on file and approved by Us.]] To qualify as a Domestic Partner , the following requirements must be met: <ol style="list-style-type: none"> 1. [the Insured and the Domestic Partner must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;] 2. [the Insured and the Domestic Partner must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;] 3. [the Insured and the Domestic Partner must both be at least 18 years of age;] 4. [neither the Insured nor the Domestic Partner are legally married;] 5. [the Insured and the Domestic Partner are not Related by blood or adoption;] 	This definition and all bracketed portions of the definition will be in or out.

<p>6. [the Insured and the Domestic Partner are each other's sole Domestic Partner and intend to remain so indefinitely;] [and]</p> <p>7. [the Insured and the Domestic Partner must be of the same sex, and if applicable law permitted, would be married.]</p> <p>The existence of the relationship between the Domestic Partner and the Insured must be evidenced by:</p> <p>1. [the Domestic Partner being named as the primary beneficiary in the event of the Insured's death under the Insured's retirement plan or 401(k) plan, if the Insured maintains such a plan;]</p> <p>2. [at least one of the following:</p> <p>a. designation of the Domestic Partner as a primary beneficiary under the Insured's will; or</p> <p>b. designation of the Domestic Partner as a primary beneficiary for the Insured's life insurance;]</p> <p>3. [at least one of the following:</p> <p>a. joint ownership of real estate (whether by mortgage, lease or deed);</p> <p>b. joint ownership of a motor vehicle; or</p> <p>c. joint ownership of a bank account; and]</p> <p>4. [a completed, active certification of Domestic Partner status form on file with the Policyholder.]</p> <p>To be active, the Insured will not have completed a Termination of Domestic Partner status form with respect to the Domestic Partner who is to be covered under the Policy.]</p>	
[Foreign National] means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]	This will be in or out.
[Non-Contributory] means that the premium payments require no contribution from the Insured .]	This will be in or out.
[Past Member] means a member who is no longer active according to the rules of the Policyholder .]	This will be in or out.
<p>[Physician] means a person who is:</p> <p>1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;</p> <p>2. licensed to practice in the jurisdiction where care is being given;</p> <p>3. practicing within the scope of that license; and not Related to You by blood or marriage.]</p>	This will be in or out.
[Plan] means the Plan design as described in the Schedule.]	This will be in or out.
[Related] means [Your Spouse or other adult living with You] [the Insured's Spouse/Domestic Partner] or other adult living with the Insured], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.]	This will be in or out.
<p>[Retiree] means a former employee of the Policyholder:</p> <p>1. [whose age plus years of service equals at least [60-70];]</p>	This will be in or out.

<p>2. [who has attained the normal retirement age;]</p> <p>3. [who has completed at least [1-10] years of active full-time or part-time service with the Policyholder;</p> <p>4. [who is participating in a Policyholder-sponsored pension plan;][or]</p> <p>5. [who retired from the Policyholder immediately after the last day as an Active Employee.]</p>	
<p>[Service Waiting Period] means the continuous length of time a person is required to be [employed][a member][by][of] the Policyholder prior to being covered under this Policy.]</p>	<p>This will be in or out. If in, the Service Waiting Period is defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p>
<p>Spouse means the Insured's legally married Spouse [under age 70]. [A Spouse will only be a covered Spouse if a Plan covering the Insured's Spouse is selected.]</p>	<p>[under age 70] will be in or out. If in, the range will be 65 – 90. The last section of this definition will be in or out.</p>
<p>[You or Your] means the Insured to whom a Certificate is issued.]</p>	<p>This will be in or out.</p>

SECTION IV – GENERAL EXCLUSIONS

1., 2., 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16.	Each Exclusion will be in or out.
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SECTION VI – PREMIUMS

<p>Premiums. Premiums are due and payable to Us at the rates and in the manner described in the [Schedule][Policyholder Application]. All rates are expressed and all premiums are payable in United States currency. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date. Except in the case of fraud, premium adjustments will be made only for the current Policy Period and the prior Policy Period.</p>	<p>[Schedule] will be in or out. [Policyholder Application] will be in or out.</p>
<p>Grace Period. Premiums are due for this Policy on or before the premium due date or renewal date, whichever applies. If the Policyholder does not pay a renewal premium when it is due, there is a [thirty-one (31)] day Grace Period to pay. During the Grace Period, the Policy will stay in force. The Policyholder will not have a Grace Period if We have given notice, at least [thirty (30)] days in advance, that We are going to terminate this Policy.</p>	<p>[thirty-one (31)] The range will be 10 - 90 [thirty (30)] The range will be 10 - 90</p>
<p>Change in Premium. We may change the premium as a condition of any renewal of this Policy by giving [at least [31] days] written notice to the Policyholder. We may also change premium at any time when any change, agreed upon in writing, between the Policyholder and Us is made that affects coverage or if it is discovered that there was a material misrepresentation in the information relied upon in establishing the premiums.</p>	<p>[at least [31] days] will be in or out. If in: [31] the range will be 10 - 90</p>

SECTION VII - TERMINATION OF INSURANCE

Termination by Policyholder. The Policyholder may terminate	
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<p>this Policy on the first renewal date or at any time after that date by delivering to Us a written notice to end this Policy at least [thirty (30)] days in advance of such termination. We will calculate and return the unearned premium, if any, using a standard short rate table. The Policyholder will send Us any additional amounts owed, if any, between the Policy's paid to date and the official date of termination.</p>	<p>[thirty (30)] The range will be 10 - 90</p>
<p>Termination by Us. We may terminate this Policy by giving the Policyholder at least [thirty (30)] days notice of Our intent to terminate. Such notice will state the exact date the Policy will terminate. We may also end this Policy for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. We will mail a notice of such termination to the Policyholder's last address shown in Our records.</p>	<p>[thirty (30)] The range will be 10 - 90</p>
<p>A. Termination of Covered Person's Insurance. [Insured. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:</p> <ol style="list-style-type: none"> 1. the Policy is terminated; 2. the Insured ceases to be eligible for insurance; 3. the Insured fails to pay the required premium, if the Insured is so required; 4. [the Insured reaches age [70]]; 5. [the Insured retires].] <p>[Insured. Insurance automatically terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date the Policy is terminated; 2. the date the Insured ceases to be eligible for insurance; 3. the expiration date of the period for which required premium has been paid for such Insured; 4. the date the Insured fails to pay the required premium, if the Insured is so required; 5. [the date the Insured reaches age [70]]; 6. [the date the Insured retires].] <p>[If an Insured has received approval for a benefits eligible leave of absence, layoff or sabbatical from the Policyholder in accordance with the Policyholder's written Policy, his or her insurance under this Policy will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this Policy with the exception of number 2. above.]</p> <p>[Covered Person other than the Insured. Insurance terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date the insurance of the Insured terminates; 2. the first premium due date after the person no longer qualifies as a Covered Person; 3. for the Covered Spouse[/Domestic Partner], the date the Covered Spouse[/Domestic Partner] reaches age [70].] 	<p>This section will be in or out. If in: [month] will be in or out. [date] will be in or out.</p> <p>4. will be in or out. If in: [70] the range will be 65 - 90 5. will be in or out.</p> <p>This section will be in or out. If in:</p> <p>5. will be in or out. If in: [70] the range will be 65 - 90 6. will be in or out.</p> <p>This section will be in or out.</p> <p>This section will be in or out. If in:</p> <p>[70] The range will be 65 - 90</p>

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SECTION VIII - HOW TO FILE A CLAIM

<p>Notice. The Insured or the beneficiary, or someone on their behalf, must give Us written notice of the Covered Loss within [ninety (90)] days of such Covered Loss, or as soon thereafter as reasonably possible. The notice must name [the Covered Person who sustained the Injury,] the Insured, and the Policy Number. To request a claim form, the Insured or the beneficiary, or someone on their behalf may contact Us at [1-866-841-4771.] The notice must be sent to the address shown on the Schedule, or any of Our agents. Notice to Our agents is considered notice to Us.</p>	<p>[ninety (90)] The range will be 10 - 365</p> <p>[the Covered Person who sustained the Injury,] will be in or out.</p> <p>[1-866-841-4771.] This is variable in the event Our telephone number changes.</p>
<p>Claim Forms. We will send the claimant Proof of Covered Loss forms within [fifteen (15)] days after We receive notice. If the claimant does not receive the Proof of Covered Loss form in [fifteen (15)] days after submitting notice, he or she can send Us a detailed written report of the claim and the extent of the Covered Loss. We will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.</p>	<p>[fifteen (15)] The range will be 15 - 60</p> <p>[fifteen (15)] The range will be 15 - 60</p>
<p>Proof of Covered Loss. Written Proof of Covered Loss, acceptable to Us, must be sent within [ninety (90)] days of the Covered Loss. Failure to furnish Proof of Covered Loss acceptable to Us within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.</p>	<p>[ninety (90)] The range will be 30 - 180</p>

SECTION IX - PAYMENT OF CLAIMS

<p>All Other Claims. Benefits are to be paid to the [Covered Person][Insured]. [He or she may direct in writing that all, or part of the Accident Medical Expense Benefit, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the [Covered Person][Insured] at any time up to the filing of the Proof of Covered Loss].</p>	<p>The last portion of this provision will be in or out.</p>
<p>[If a Foreign National is entitled to benefits for a Covered Loss and We are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such Foreign National is located, We will either: (1) pay the benefits to a bank account owned by the Foreign National in the United States of America; or (2) if no such bank account is established or maintained, We will pay the benefits to the Policyholder on behalf of the Foreign National. It will then be the responsibility of the Policyholder to remit the benefit to such Foreign National. Payment of the benefit to the Policyholder will release Us from any further liability to the Foreign National. If the Policyholder does not remit the payment to the Foreign National, the Policyholder will indemnify Us and hold Us harmless against any and all liability incurred by Us including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The Policyholder will not be considered the beneficiary under the Policy if payment is</p>	<p>This provision will be in or out.</p>

made to the **Policyholder** in accordance with this provision.]

SECTION X - GENERAL POLICY CONDITIONS

Policyholder Records. The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.]

The last portion of this provision will be in or out.

[Reduction Schedule. [At age [70], [for the **Insured** only,] the **Principal Sum** will be reduced based on the [Covered Person's] **Insured's** previous **Principal Sum** per the following schedule shown below for **Your** attained age:

Age at Date of Loss	Percent of Original Principal Sum
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if:

1. **You** become covered under the **Policy**; or
2. **Your** coverage increases;
3. On or after the date **You** attain age [70].]

This provision will be in or out. If in:
[At age [70], [for the **Insured** only,] will be in or out and the range will be 65 - 80.

[Age 70-74] the range will be 65 - 74
[65%] the range will be 50% - 100%
[Age 75-79] the range will be 75 - 79
[45%] the range will be 25% - 65%
[Age 80-84] the range will be 80 - 84
[30%] the range will be 10% - 50%
[Age 85 or over] the range will be 85 - 100
[15%] the range will be 5% - 25%

[70] the range will be 65 - 80

[Choice of Service Provider. The [Covered Person] **Insured** has the sole right to choose his or her duly licensed **Physician** and hospital.]

This provision will be in or out.

[Arbitration. Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the [Covered Person] **Insured**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the [Covered Person] **Insured** is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the [Covered Person] **Insured**]].

This provision will be in or out.

SECTION XI – COVERAGES

[[ACCIDENTAL DEATH [AND DISMEMBERMENT]]COVERAGE

If [a **Covered Person**] [an **Insured**] [or a covered **Spouse** [/**Domestic Partner**]] [suffers a loss of life as a result of a **Covered Injury**], **We** will pay the applicable **Principal Sum**. The death must occur within [365] days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] [an **Insured**] [or a covered **Spouse**[/**Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of

1. [Both Hands or Both Feet [100% of **Principal Sum**]
2. One Hand and One Foot [100% of **Principal Sum**]
3. One Hand or One Foot plus the loss of Sight of One Eye [100% of **Principal Sum**]
4. Sight of Both Eyes [100% of **Principal Sum**]
5. Speech and Hearing [100% of **Principal Sum**]
6. Speech or Hearing [50% of **Principal Sum**]
7. One Hand; One Foot; or Sight of One Eye [50% of **Principal Sum**]
8. Thumb and Index Finger of the same Hand [25% of **Principal Sum**]
9. Hearing in One Ear [25% of **Principal Sum**]

This coverage is subject to all **Policy** terms, limitations, and exclusions.

This entire section will be in or out.

If Accidental Death Coverage is in:
[or a covered **Spouse** [/**Domestic Partner**]] will be in or out;
[suffers a loss of life as a result of a **Covered Injury**] will be in or out;
[365] The range will be 30 - 365.

This section will be in or out. If Accidental Dismemberment Coverage is in:
[or a covered **Spouse**[/**Domestic Partner**]] will be in or out;
[365] The range will be 30 - 365;

Any combination of 1 - 9 may be in or out. If in:
The range will be 50% - 200%
The range will be 50% - 200%

The range will be 50% - 200%
The range will be 50% - 200%
The range will be 50% - 200%
The range will be 25% - 100%
The range will be 25% - 100%

The range will be 10% - 75%

The range will be 10% - 75%

[EXPOSURE AND DISAPPEARANCE COVERAGE

If [a **Covered Person**] [an **Insured**] is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [a **Covered Person**] [an **Insured**] is riding disappears, is wrecked, or sinks, and the [**Covered Person**] [**Insured**] is not found within [365 days] of the event, **We** will presume that the person lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the [**Covered Person**] [**Insured**] survived the event.]

This will be in or out. If in:

[365] The range will be 180 - 365

SECTION XII – IMPORTANT NOTICE

The [**Insured**] [**Covered Person**] may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the [**Insured**] [**Covered Person**] can write to Zurich American Insurance Company at their administrative offices at

The appropriate toll free number will be inserted.

[XXXXXX].

Should the [Insured] [Covered Person] wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the [Insured] [Covered Person] may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

The appropriate mailing address will be inserted.

POLICYHOLDER APPLICATION – U-GMC-101-A AR (08/09)

<p>ELIGIBILITY AND CLASSIFICATION OF INSURED:</p> <p>Class I: [Active Employees working a minimum of [15 hours] per week.] [Active Members]</p> <p>[Class II: [Retirees] [Past Members]]</p> <p>[Class III: [Dependents.]]</p>	<p>Class definitions are variable and defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p> <p>[15 hours] The range will be 0 - 40</p> <p>If there is more than one Class eligible under the Policy a Schedule of Benefits may be presented for each Class if benefit applicability, amounts and duration differ by class or it may be presented in the aggregate.</p>										
<p>[SERVICE WAITING PERIOD: [[30 days] of Active continuous service.]]</p>	<p>This provision will be in or out.</p> <p>The Service Waiting Period is variable and defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p> <p>[30 days] The range will be 0 – 120 days.</p>										
<p>PRINCIPAL SUM:</p> <p>Class I: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].</p> <p>[Class II: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].]]</p> <p>[[The Principal Sum for Covered Dependents will be a percentage of the Insured's Principal Sum, as follows:</p> <p>Plan Selected % Spouse[/Domestic Partner]% Child(ren)</p> <p>Spouse[/Domestic Partner] only: [50%]</p> <p>Dependent Child(ren) only: [15%]</p> <p>Spouse[/Domestic Partner] and Dependent Child(ren):</p> <p>[40%] [10%]]</p>	<p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>This will be in for a Voluntary Policy only. If in:</p> <p>[50%] The range will be 25% - 100%</p> <p>[15%] The range will be 5% - 50%</p> <p>[40%] The range will be 25% - 100%</p> <p>[10%] The range will be 5% - 50%</p>										
<p>[Reduction of Principal Sum:</p> <p>If [an Insured] [a Covered Person] is age [70] or older on the date of an a Covered Accident , the Principal Sum used to calculate benefits will be the following percentage of the applicable Principal Sum indicated above:</p> <table data-bbox="207 1707 716 1892"> <thead> <tr> <th>Age at Date of Loss</th><th>Percent of Original Principal Sum</th></tr> </thead> <tbody> <tr> <td>[Age 70-74]</td><td>[65%]</td></tr> <tr> <td>[Age 75-79]</td><td>[45%]</td></tr> <tr> <td>[Age 80-84]</td><td>[30%]</td></tr> <tr> <td>[Age 85 or over]</td><td>[15%]</td></tr> </tbody> </table>	Age at Date of Loss	Percent of Original Principal Sum	[Age 70-74]	[65%]	[Age 75-79]	[45%]	[Age 80-84]	[30%]	[Age 85 or over]	[15%]	<p>This provision will be in or out. If in:</p> <p>[At age [70], [for the Insured only,] will be in or out and the range will be 65 - 80.</p> <p>[Age 70-74] the range will be 65 - 74</p> <p>[65%] the range will be 50% - 100%</p> <p>[Age 75-79] the range will be 75 - 79</p> <p>[45%] the range will be 25% - 65%</p> <p>[Age 80-84] the range will be 80 - 84</p> <p>[30%] the range will be 10% - 50%</p>
Age at Date of Loss	Percent of Original Principal Sum										
[Age 70-74]	[65%]										
[Age 75-79]	[45%]										
[Age 80-84]	[30%]										
[Age 85 or over]	[15%]										

<p>[Rehabilitation Benefit] [[10%] of the [Covered Person's] [Insured's] Principal Sum or to a maximum of [\$10,000] [\$10,000]</p> <p>[Seat Belt/[Air Bag] Benefit] [Seat Belt - [10%] of the Principal Sum to a maximum of [\$10,000] [\$10,000]</p> <p>[Air Bag - [10%] of the Principal Sum to a maximum of [\$10,000]] [\$10,000]</p> <p>[[]]</p>	<p>[10%] The range will be 1% - 100% [\$10,000] The range will be \$1,000 - \$50,000 [\$10,000] The range will be \$1,000 - \$50,000</p> <p>[10%] The range will be 5% - 50% [\$10,000] The range will be \$1,000 - \$100,000 [\$10,000] The range will be \$1,000 - \$100,000</p> <p>[10%] The range will be 5% - 50% [\$10,000] The range will be \$1,000 - \$100,000 [\$10,000] The range will be \$1,000 - \$100,000</p> <p>Additional Benefit Riders and benefit amounts may be added as filed and approved by the State.</p>
<p>[[AGGREGATE] LIMIT OF LIABILITY [for air travel] [\$5,000,000] per Covered Accident]]</p>	<p>This provision will be in or out. If in: [Aggregate] will be in or out; [for air travel] will be in or out; [\$5,000,000] The range will be \$1,000 - \$50,000,00;</p>
<p>PREMIUMS: Due Date: [First day of each month] [Policy Inception Date] Amount Due:</p>	<p>Either will be in or out. The amount(s) due will vary by calculation and coverages selected.</p>

GROUP ACCIDENT INSURANCE CERTIFICATE – U-GMC-102-A AR (08/09)

Face Page

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.] THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE [ONLY] [THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS]	[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.] will be in or out. [ONLY] will be in or out. [THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS] will be in or out.
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SECTION I – SCHEDULE

POLICYHOLDER: [John Doe Corporation] [123 Main Street] [Anywhere, XX 10011] [COVERED SUBSIDIARIES OR AFFILIATED COMPANIES: [ABC Company]] POLICY NUMBER: [ABC-1234567] POLICY INCEPTION DATE: [January 1, 2010] POLICY PERIOD: [Effective Date] to [Expiration Date] [Continuous] [INSURED: [Insured's Name] [Street Address] [City, State Zip]] [CERTIFICATE NUMBER: [XXXXXXX-XX]] [COVERED DEPENDENTS: [Spouse's/Domestic Partner's] Name] [Dependent Child(ren)'s Name(s)] PREMIUM: [\$00.00] Payable [Monthly]	Name of the Policyholder will be inserted. Address of the Policyholder will be inserted. City, State and Zip Code of the Policyholder will be inserted. This will be in-or-out. If in, the Policyholder's subsidiaries or affiliated companies will be inserted. Policy number will be inserted. Policy Inception Date will be inserted. Effective Date will be inserted. Expiration Date will be in-or-out. If in, the Expiration Date will be inserted. Continuous will be in-or-out. This section will be in or out. If in: Insured's Name, Address, City, State and Zip will be inserted. This section will be in or out. If in: Certificate Number will be inserted. This section will be in or out. If in: This will be in or out. If in, Spouse's/Domestic Partner's Name will be inserted; This will be in or out. If in, Dependent Child(ren)'s Name(s) will be inserted. [\$00.00] Varies by calculation [Monthly] The range will be monthly, bi-monthly, quarterly, annually, etc.
ELIGIBILITY AND CLASSIFICATION OF INSURED: [completion of the Service Waiting Period as indicated below, and] the submission of completed enrollment material, if required: Class I: [Active Employees working a minimum of [15 hours] per week.] [Active Members] [Class II: [Retirees] [Past Members]] [Class III: [Dependents.]]	This will be in-or-out. Class definitions are variable and defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.

	<p>[15 hours] The range will be 0 - 40</p> <p>If there is more than one Class eligible under the Policy a Schedule of Benefits may be presented for each Class if benefit applicability, amounts and duration differ by class or it may be presented in the aggregate.</p>
<p>[SERVICE WAITING PERIOD: [[30 days] of Active continuous service.]]</p>	<p>This provision will be in or out.</p> <p>The Service Waiting Period is variable and defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.</p> <p>[30 days] The range will be 0 – 120 days.</p>
<p>PRINCIPAL SUM:</p> <p>Class I: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].</p> <p>[Class II: [An [employee] [member] may purchase an amount of Principal Sum from a minimum of [\$1,000] to a maximum of [\$50,000,000].]]</p> <p>[The Principal Sum for covered Dependents will be a percentage of the Insured's Principal Sum, on the date of Accident, determined by multiplying Your Principal Sum by the percentage below.</p> <p><u>Plan Selected % Spouse[/Domestic Partner]% Child(ren)</u></p> <p>Spouse[/Domestic Partner] only: [50%] [15%]</p> <p>Dependent Child(ren) only: [15%]</p> <p>Spouse[/Domestic Partner] and Dependent Child(ren): [40%] [10%]]</p>	<p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>The Principal Sum for each Class will be inserted. The standard will be \$1,000,000 and the range will be \$1,000 - \$50,000,000.</p> <p>This will be in for a Voluntary Policy only. If in:</p> <p>[50%] The range will be 25% - 100% [15%] The range will be 5% - 50%</p> <p>[40%] The range will be 25% - 100% [10%] The range will be 5% - 50%</p>
<p>[[AGGREGATE] LIMIT OF LIABILITY [for air travel] [\$5,000,000] per Covered Accident</p> <p>[If the total of all benefits payable for all Covered Persons per Accident, in the absence of this provision exceeds the above amount, each benefit amount will be proportionately reduced so that the total will equal the above amount.]</p> <p>[If both Non-Contributory and Contributory coverage are included, the above list of benefits will be labeled Non-Contributory and then the benefits applicable to the Contributory coverage will be listed below.]]</p> <p>Benefits payable under any attached Riders are subject to the [Aggregate] Limit of Liability.</p>	<p>This provision will be in or out. If in: [Aggregate] will be in or out; [for air travel] will be in or out; [\$5,000,000] The range will be \$1,000 - \$50,000,00;</p> <p>This will be in or out;</p> <p>This will be in or out;</p> <p>[Aggregate] will be in or out.</p>
COVERAGES:	

This is variable in the event there is a change in the Company's mailing address and telephone number.

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<p>7. the Insured's Effective Date;</p> <p>8. the date for which the first premium for the Dependent's coverage is paid;</p> <p>9. the date the person qualifies as a Dependent; or</p> <p>10. [the date on which written enrollment for the Dependent is received by the Policyholder.]</p> <p>[Your child born while the Policy is in force is covered from the moment of birth for a period of 60 days. Your adopted newborn child is covered from the moment of birth for a period of 60 days. After this time, Your child will remain covered only if You have provided written notice of birth or the filing of a petition for adoption to the Policyholder and pays the required premium due, if any.]</p> <p>[Your newly adopted child is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 60 days. After this time, Your child will remain covered only if You have provided written notice to the Policyholder of the adoption or the filing of a petition for adoption, and pay the required premium due, if any.]</p>	<p>This will be in or out;</p> <p>This will be in or out;</p> <p>This will be in or out.</p>
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SECTION III – DEFINITIONS

[Active means [a member as defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.].]	This will be in or out. If in, Active will be defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.
[Active and Actively at Work describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Actively at Work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.]	This will be in or out.
[Active Employee means any natural persons in the regular service of the Policyholder and in the ordinary course of the Policyholder's business.]	This will be in or out.
[Active Member means a member in good standing according to the rules of the Policyholder .]	This will be in or out.
[[Aggregate] Limit of Liability means the total benefits We will pay for a Covered Accident or Covered Accidents set forth in the Schedule. For purposes of the [Aggregate] Limit of Liability provision, Covered Accident or Covered Accidents will include a Covered Loss or Covered Losses arising out of a single event or related events or originating cause [occurring within a [1] day period] and includes a resulting Covered Loss or Covered Losses . If the total benefits under the [Aggregate] Limit of Liability is not enough to pay full benefits to each [Covered Person] [Insured], We will pay each one a reduced benefit based upon the proportion that the [Aggregate] Limit of Liability bears to the total benefits which would otherwise be paid.]	<p>This definition will be in or out. If in: [Aggregate] will be in or out;</p> <p>[occurring within a [1] day period] will be in or out. If in: [1] The range will be 1 - 3 days</p>
[Contributory means that the premium payments require that	This will be in or out.

You pay all or a portion of the premium.]	
Covered Person means any person who has insurance under the terms of the Policy . It includes You [, and Your Spouse [/ Domestic Partner] and/or Dependent Child(ren) if a Plan covering Your Spouse [/ Domestic Partner] and/or Dependent Child(ren) is selected.]	This section of the definition will be in or out.
Dependent means Your Spouse [/ Domestic Partner] and Dependent Child(ren) , as defined in this section. [Your Dependent will only be a covered Dependent if a Plan covering Dependents is selected.]	This section of the definition will be in or out.
Dependent Child(ren) means Your unmarried Child(ren) , [and] [those unmarried Child(ren) of Your Spouse [/ Domestic Partner]] [, and those unmarried Child(ren) [as defined in the Policyholder's [medical] plan as on file and approved by Us] who rely on You for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [Your Dependent Child(ren) will only be covered Dependent Child(ren) if a Plan covering Dependent Child(ren) is selected.]	<p>This will be in or out. This will be in or out. This will be in or out. This will be in or out. This will be in or out. [19 (nineteen)] The range will be 18 - 30 [25 (twenty-five)] The range will be 18 - 30</p> <p>This will be in or out.</p>
<p>[Domestic Partner means [a person who qualifies as a Domestic Partner under the Policyholder's written procedures as on file and approved by Us.] [a person who qualifies as a Domestic Partner under the law of the state of residence.] [as defined in the Policyholder's [medical] plan as on file and approved by Us.]]</p> <p>To qualify as a Domestic Partner, the following requirements must be met:</p> <ol style="list-style-type: none"> 1. [You and Your Domestic Partner must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;] 2. [You and Your Domestic Partner must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;] 3. [You and Your Domestic Partner must both be at least 18 years of age;] 4. [neither You nor Your Domestic Partner are legally married;] 5. [You and Your Domestic Partner are not Related by blood or adoption;] 6. [You and Your Domestic Partner are each other's sole Domestic Partner and intend to remain so indefinitely;] [and] 7. [You and Your Domestic Partner must be of the same sex, and if applicable law permitted, would be married.] <p>The existence of the relationship between Your Domestic Partner and You must be evidenced by:</p> <ol style="list-style-type: none"> 1. [Your Domestic Partner being named as the primary beneficiary in the event of Your death under Your retirement plan or 401(k) plan, if You maintain such a 	<p>This definition and all bracketed portions of the definition will be in or out.</p>

<p>plan;]</p> <p>2. [at least one of the following:</p> <p>a. designation of Your Domestic Partner as a primary beneficiary under Your will; or</p> <p>b. designation of Your Domestic Partner as a primary beneficiary for Your life insurance;]</p> <p>3. [at least one of the following:</p> <p>a. joint ownership of real estate (whether by mortgage, lease or deed);</p> <p>b. joint ownership of a motor vehicle; or</p> <p>c. joint ownership of a bank account; and]</p> <p>4. [a completed, active certification of Domestic Partner status form on file with the Policyholder.]</p> <p>To be active, You will not have completed a Termination of Domestic Partner status form with respect to Your Domestic Partner who is to be covered under the Policy.]</p>	
[Foreign National means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]	This will be in or out.
[Non-Contributory means that the premium payments require no contribution from You .]	This will be in or out.
[Past Member means a member who is no longer active according to the rules of the Policyholder .]	This will be in or out.
<p>[Physician means a person who is:</p> <p>4. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;</p> <p>5. licensed to practice in the jurisdiction where care is being given;</p> <p>6. practicing within the scope of that license; and not Related to You by blood or marriage.]</p>	This will be in or out.
[Plan means the Plan design as described in the Schedule.]	This will be in or out.
[Related means [Your Spouse [/ Domestic Partner] or other adult living with You], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.]	This will be in or out.
<p>[Retiree means a former employee of the Policyholder:</p> <p>6. [whose age plus years of service equals at least [60-70];]</p> <p>7. [who has attained the normal retirement age;]</p> <p>8. [who has completed at least [1-10] years of active full-time or part-time service with the Policyholder;]</p> <p>9. [who is participating in a Policyholder-sponsored pension plan;][or]</p> <p>10. [who retired from the Policyholder immediately after the last day as an Active Employee.]</p>	This will be in or out.
[Service Waiting Period means the continuous length of time a person is required to be [employed][a member][by][of] the Policyholder prior to being covered under the Policy .]	This will be in or out. If in, the Service Waiting Period is defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the

	creditor and its debtors, or the vendor and its vendees, etc.
Spouse means You legally married Spouse [under age 70]. [A Spouse will only be a covered Spouse if a Plan covering Your Spouse is selected.]	[under age 70] will be in or out. If in, the range will be 65 – 90. The last section of this definition will be in or out.
[You or Your means the Insured to whom a Certificate is issued.]	This will be in or out.

SECTION IV – GENERAL EXCLUSIONS

1., 2., 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16.	Each Exclusion will be in or out.
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SECTION VI – PREMIUMS

Grace Period. Premiums are due on or before the premium due date or renewal date, whichever applies. If You do not pay premium when it is due, there is a [thirty-one (31)] day Grace Period to pay. During the Grace Period, Your coverage under the Policy will stay in force.	[thirty-one (31)] The range will be 10 - 90
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SECTION VII - TERMINATION OF INSURANCE

<p>A. Termination of Covered Person's Insurance.</p> <p>[Insured. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:</p> <ol style="list-style-type: none"> 1. the Policy is terminated; 2. You cease to be eligible for insurance; 3. You fail to pay the required premium, if You are so required; 4. [You reach age [70]]; 5. [You retire.] <p>[Insured. Insurance automatically terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date the Policy is terminated; 2. the date You cease to be eligible for insurance; 3. the expiration date of the period for which required premium has been paid for You; 4. the date You fail to pay the required premium, if You are so required; 5. [the date You reach age [70]]; 6. [the date You retire.] <p>[If You have received approval for a benefits eligible leave of absence, layoff or sabbatical from the Policyholder in accordance with the Policyholder's written Policy, Your insurance under the Policy will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of the Policy with the exception of number 2. above.]</p> <p>[Covered Person other than the Insured. Insurance terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date Your insurance terminates; 2. the first premium due date after the person no longer qualifies as a Covered Person; 3. [for Your Covered Spouse/Domestic Partner], the 	<p>This section will be in or out. If in:</p> <p>[month] will be in or out. [date] will be in or out.</p> <p>4. will be in or out. If in: [70] the range will be 65 - 90 5. will be in or out.</p> <p>This section will be in or out. If in:</p> <p>5. will be in or out. If in: [70] the range will be 65 - 90 6. will be in or out.</p> <p>This section will be in or out.</p> <p>This section will be in or out. If in:</p>
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date Your Covered Spouse/Domestic Partner reaches age [70].]	[70] The range will be 65 - 90
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SECTION VIII - HOW TO FILE A CLAIM

<p>Notice. You or Your beneficiary, or someone on Your behalf, must give Us written notice of the Covered Loss within [ninety (90)] days of such Covered Loss, or as soon thereafter as reasonably possible. The notice must name [the Covered Person who sustained the injury,] You, and the Policy Number. To request a claim form, You or Your beneficiary, or someone on Your behalf may contact Us at [1-866-841-4771.] The notice must be sent to the address shown on the Schedule, or any of Our agents. Notice to Our agents is considered notice to Us.</p>	<p>[ninety (90)] The range will be 10 - 365</p> <p>[the Covered Person who sustained the Injury,] will be in or out.</p> <p>[1-866-841-4771.] This is variable in the event Our telephone number changes.</p>
<p>Claim Forms. We will send the claimant Proof of Covered Loss forms within [fifteen (15)] days after We receive notice. If the claimant does not receive the Proof of Covered Loss form in [fifteen (15)] days after submitting notice, he or she can send Us a detailed written report of the claim and the extent of the Covered Loss. We will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.</p>	<p>[fifteen (15)] The range will be 15 - 60</p> <p>[fifteen (15)] The range will be 15 - 60</p>
<p>Proof of Covered Loss. Written Proof of Covered Loss, acceptable to Us, must be sent within [ninety (90)] days of the Covered Loss. Failure to furnish Proof of Covered Loss acceptable to Us within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.</p>	<p>[ninety (90)] The range will be 30 - 180</p>

SECTION IX - PAYMENT OF CLAIMS

<p>All Other Claims. Benefits are to be paid to [the Covered Person][You]. [The Covered Person][You] may direct in writing that all, or part of the Accident Medical Expense Benefit, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by [the Covered Person][You] at any time up to the filing of the Proof of Covered Loss].</p>	<p>The last portion of this provision will be in or out.</p>
<p>[If a Foreign National is entitled to benefits for a Covered Loss and We are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such Foreign National is located, We will either: (1) pay the benefits to a bank account owned by the Foreign National in the United States of America; or (2) if no such bank account is established or maintained, We will pay the benefits to the Policyholder on behalf of the Foreign National. It will then be the responsibility of the Policyholder to remit the benefit to such Foreign National. Payment of the benefit to the Policyholder will release Us from any further liability to the Foreign National. If the Policyholder does not remit the payment to the Foreign National, the Policyholder will indemnify Us and hold Us harmless against any and all liability incurred by Us including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The Policyholder will not</p>	<p>This provision will be in or out.</p>

be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]

SECTION X - GENERAL POLICY CONDITIONS

[Reduction Schedule. [At age [70], [for **You** only,] the **Principal Sum** will be reduced based on [the **Covered Person's**] [**Your**] previous **Principal Sum** per the following schedule shown below for **You** attained age:

Age at Date of Loss	Percent of Original Principal Sum
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if:

1. **You** become covered under the **Policy**; or
2. **Your** coverage increases;
3. On or after the date **You** attain age [70].]

This provision will be in or out. If in:
[At age [70], [for the **Insured** only,] will be in or out and the range will be 65 - 80.

[Age 70-74] the range will be 65 - 74
[65%] the range will be 50% - 100%
[Age 75-79] the range will be 75 - 79
[45%] the range will be 25% - 65%
[Age 80-84] the range will be 80 - 84
[30%] the range will be 10% - 50%
[Age 85 or over] the range will be 85 - 100
[15%] the range will be 5% - 25%

[70] the range will be 65 - 80

[Choice of Service Provider. [The **Covered Person** has] [**You** have] the sole right to choose [his or her] [**Your**] duly licensed **Physician** and hospital.]

This provision will be in or out.

[Arbitration. Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to [the **Covered Person**] [**You**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if [the **Covered Person** is] [**You** are] a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by [the **Covered Person**] [**You**].

This provision will be in or out.

SECTION XI – COVERAGES

[[ACCIDENTAL DEATH [AND DISMEMBERMENT]]COVERAGE

If [a **Covered Person**] [**You**] [or **Your** covered **Spouse** [/**Domestic Partner**]] [suffers a loss of life as a result of a **Covered Injury**], **We** will pay the applicable **Principal Sum**. The death must occur within [365] days of the **Covered Injury**.

This entire section will be in or out.

If Accidental Death Coverage is in:
[or a covered **Spouse** [/**Domestic Partner**]] will be in or out;
[suffers a loss of life as a result of a **Covered Injury**] will be in or out;
[365] The range will be 30 - 365.

<p>[If a Covered Injury to [a Covered Person] [You] [or Your covered Spouse[/Domestic Partner]] results in any of the following Covered Losses, We will pay the benefit amount shown. The Covered Loss must occur within [365] days of the Accident.</p> <p>The benefit amounts are based on the Principal Sum of the person suffering the Covered Loss.</p> <p>Covered Loss of</p> <ol style="list-style-type: none"> 1. [Both Hands or Both Feet [100% of Principal Sum] 2. One Hand and One Foot [100% of Principal Sum] 3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum] 4. Sight of Both Eyes [100% of Principal Sum] 5. Speech and Hearing [100% of Principal Sum] 6. Speech or Hearing [50% of Principal Sum] 7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum] 8. Thumb and Index Finger of the same Hand [25% of Principal Sum] 9. Hearing in One Ear [25% of Principal Sum] <p>This coverage is subject to all Policy terms, limitations, and exclusions.</p>	<p>This section will be in or out. If Accidental Dismemberment Coverage is in: [or a covered Spouse[/Domestic Partner]] will be in or out; [365] The range will be 30 - 365;</p> <p>Any combination of 1 - 9 may be in or out. If in: The range will be 50% - 200% The range will be 50% - 200%</p> <p>The range will be 50% - 200% The range will be 50% - 200% The range will be 50% - 200% The range will be 25% - 100% The range will be 25% - 100%</p> <p>The range will be 10% - 75%</p> <p>The range will be 10% - 75%</p>
<p>[EXPOSURE AND DISAPPEARANCE COVERAGE] If [a Covered Person is] [You are] exposed to weather because of an Accident and this results in a Covered Loss, We will pay the applicable Principal Sum, subject to all Policy terms. If the conveyance in which [a Covered Person is] [You are] riding disappears, is wrecked, or sinks, and [the Covered Person is] [You are] not found within [365 days] of the event, We will presume that [the person lost his or her] [You lost Your] life as a result of injury. If travel in such conveyance was covered under the terms of the Policy, We will pay the applicable Principal Sum, subject to all Policy terms. We have the right to recover the benefit if We find that [the Covered Person] [You] survived the event.]]</p>	<p>This will be in or out. If in:</p> <p>[365] The range will be 180 - 365</p>

SECTION XII – IMPORTANT NOTICE

<p>You may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if You need assistance in resolving any complaints. Or, You can write to Zurich American Insurance Company at their administrative offices at [XXXXXX].</p> <p>Should You wish to contact the Arkansas Insurance Department for assistance, You may do so by calling [1-800-282-9134]. Or, You may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].</p>	<p>The appropriate toll free number will be inserted.</p> <p>The appropriate mailing address will be inserted.</p>
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ENROLLMENT FORM – U-GMC-103-A AR (08/09)

The Enrollment Form will only be used when a Policy is issued as a Voluntary Policy.

POLICYHOLDER INFORMATION [Master Policy Number:]	This will be in or out.
ENROLLEE INFORMATION [Certificate Number (assigned by the Company):]	This will be in or out.
INSURANCE REQUESTED Plan Selected <input type="checkbox"/> Spouse [or Domestic Partner] Only [as per the Schedule] <input type="checkbox"/> Dependent Child(ren) Only [as per the Schedule] <input type="checkbox"/> Spouse [or Domestic Partner] and Dependent Child(ren) [as per the Schedule] [The Principal Sum for Covered Dependents will be a percentage of the Enrollee's Principal Sum .] [Coverage(s) Included: [Accidental Death Coverage] [as per the Schedule] [Dismemberment Coverage] [as per the Schedule] [Exposure and Disappearance Coverage] [as per the Schedule] [] [as per the Schedule] [Benefit(s) Included: [[Higher] Education Benefit] [as per the Schedule] [Common Carrier Benefit] [as per the Schedule] [Common Disaster Benefit] [as per the Schedule] [Carjacking Benefit] [as per the Schedule] [Felonious Assault Benefit] [as per the Schedule] [Identity Theft Resolution Services] [as per the Schedule] [Rehabilitation Benefit] [as per the Schedule] [Seat Belt/[Air Bag] Benefit] [as per the Schedule] [] [as per the Schedule]	This will be in or out. This will be in or out. This will be in or out. This will be in or out. This entire section will be in or out. If in: Any combination of Coverages may be in or out; Additional Coverages and Coverage Amounts may be included as filed and approved by the State. This entire section will be in or out. If in: Any combination of Benefit(s) may be in or out; Additional Benefit(s) and Benefit Amounts may be included as filed and approved by the State.
PREMIUM INFORMATION Method of Payment: <input type="checkbox"/> Direct Bill]	This will be in or out.
[AGENT INFORMATION [Producer Number:]]	This entire section will be in or out. If in: This will be in or out.

BLANK ENDORSEMENT – U-GMC-104-A CW (08/09)

[This endorsement will be used to make the following changes to the **Policy/Certificate**, which are administrative in nature: (1) changes to the Schedule; (2) addition or deletion of a subsidiary or affiliates of the **Policyholder**; (3) changes to the classes of covered persons; (4) annual audit requirement; and (5) other administrative changes to the **Policy/Certificate**.]

This endorsement will be used to make administrative changes to the Policy/Certificate.

[HIGHER] EDUCATION BENEFIT – U-GMC-110-A CW (08/09)

<p>If the Insured [or the Insured's Spouse[/Domestic Partner] [selects a Plan covering his or her Dependent Child(ren) and the Insured] suffers a Covered Injury resulting in a Covered Loss, which is payable under the [Accidental Death] Coverage, We will pay an additional benefit for [higher] education expenses incurred for each Dependent Child.</p> <p>[A Dependent Child is eligible for the [Higher] Education Benefit if on the date of the Covered Accident: 1. he or she is enrolled as a full-time Student in an accred- ited college, university or trade school; or 2. he or she is at the 12th grade level and enrolls in an ac- credited college, university or trade school within one (1) year from the date of the Covered Accident.]</p> <p>The [Higher] Education Benefit will be equal to the amount shown on the Schedule per Dependent Child. [This amount will be paid annually for up to [four (4)] consecutive years if the Dependent Child continues his or her education. Before this benefit is paid each year, the Dependent Child must present written proof, acceptable to Us, that he or she is attend- ing an institution of [higher] learning on a full-time basis.]</p> <p>[If, at the time of the Covered Accident, a Plan covering the In- sured's Dependents was selected, but there are no Dependent Child(ren) who qualify for this benefit, We will pay an additional benefit of [\$1,000] to the designated beneficiary.]</p>	<p>This will be in or out. This will be in or out.</p> <p>This will be in or out, This will be in or out.</p> <p>This section will be in or out. If in: This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in: [four (4)] The range will be 1 - 6 [higher] will be in or out.</p> <p>This will be in or out. If in: [\$1,000] The range will be \$500 - \$5,000</p>
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COMMON CARRIER BENEFIT – U-GMC-111-A CW (08/09)

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death [and Accidental Dismemberment]] Coverage**, **We** will pay an additional benefit equal to the amount in the Schedule, provided the **[Covered Person] [Insured]** suffers the **Covered Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

This will be in or out. If in:
and Accidental Dismemberment will be in or out.

COMMON DISASTER BENEFIT – U-GMC-112-A CW (08/09)

If an **Insured** selects a **Plan** covering his or her **Dependents** and the **Insured** and his or her **Covered Spouse** [/Domestic Partner] are both eligible for

[Accidental Death]

Coverage as a result of **Covered Injuries** suffered in the same **Covered Accident**

[and within [90 days] of such **Covered Accident**.]

the **Principal Sum** that would have been payable because of the **Covered Spouse's** [/Domestic Partner's] **Accidental Death** will be increased to equal that payable for the **Covered Loss** of the **Insured**, provided

[the **Insured** and **Covered Spouse**[/Domestic Partner] are survived by one or more **Covered Dependent Child(ren)**; and] the combined benefits of the **Insured** and the **Covered Spouse** [/Domestic Partner] are not more than the amount shown on the Schedule.

For purposes of this benefit only, the following definitions apply:

Covered Dependent Child(ren) means [an] eligible **Dependent Child(ren)** who has insurance under the terms of this rider.

Covered Spouse [/Domestic Partner] means an eligible **Spouse** [/Domestic Partner] who has insurance under the terms of this rider.

This will be in or out.

This will be in or out. If in, the range will be 30 - 365.

This will be in or out.

CARJACKING BENEFIT – U-GMC-113-A CW (08/09)

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death [and Accidental Dismemberment]] Coverage**, as a direct result of a **Covered Accident** that occurs during a **Carjacking** of a private passenger vehicle that the **[Covered Person] [Insured]** was operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to the amount shown on the Schedule.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24) hours] of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24) hours] or as soon as reasonably possible, and such verification must be provided to **Us**.

This will be in or out. If in:
[and Accidental Dismemberment] will be in or out.

[twenty-four (24) hours] The range will be 12 - 48
[twenty-four (24) hours] The range will be 12 - 48

FELONIOUS ASSAULT BENEFIT – U-GMC-114-A CW (08/09)

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death [or Accidental Dismemberment]] Coverage** as a result of a violent or criminal act committed by someone other than the **Insured**, **[a Fellow Employee]** or a member of his or her **Family or Household**, **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this benefit only, the following definitions apply:
[Fellow Employee] means a person employed by the same employer as the **Insured** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than **[forty-five (45)]** days prior to the date on which the defined violent crime/felonious assault was committed.]

This will be in or out. If in:
[and Accidental Dismemberment] will be in or out.

This will be in or out.

This will be in or out. If in:

[forty-five (45)] The range will be 10 - 90.

REHABILITATION BENEFIT – U-GMC-115-A CW (08/09)

If the [Insured][Covered Person] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Dismemberment]

Coverage, We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2) years] from the date of the **Covered Accident** for the **Rehabilitation Training**; or
2. the maximum amount shown in the Schedule.

For this benefit only, the following definitions apply:

Pre-existing Condition means a condition for which a **Covered Person** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [6] months immediately preceding the **Covered Loss**.

This will be in or out.

[two (2) years] The range will be 6 months – 4 years

[6] The range will be 6 - 12.

SEAT BELT/[AIR BAG] BENEFIT – U-GMC-116-A CW (08/09)

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the **[Accidental Death][and Dismemberment]**

Coverage, and the **Covered Injury** which caused the **Accidental** death directly resulted from an automobile **Covered Accident**, **We** will pay an additional **Seat Belt Benefit**, which equals the amount shown in the Schedule, provided that the **[Covered Person]** **[Insured]** was:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the **[Covered Person's]** **[Insured's]** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional **Air Bag Benefit** equal to the amount shown in the Schedule, will be paid if the **[Covered Person]** **[Insured]** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **[Covered Person's]** **[Insured's]** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[We will not pay a Seat Belt [or Air Bag] Benefit to the [Covered Person] [Insured] that was driving either:

1. under the influence of alcohol:
 - a. A driver will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred;
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]

This will be in or out. If in:

[and Accidental Dismemberment] will be in or out.

The Air Bag Benefit will be in or out.

This provision will be in or out. If in:

[or Air Bag] will be in or out.